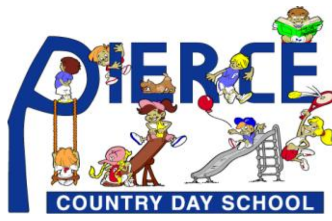

MEDICAL FORM

Student's Full Name ____ **Date of Birth** ___________________

Home Street Address ____

City ____ **State** ______________ **Zip Code** ______________

Home Telephone Number ____

Father's Name ________________________________ **Father's Cell #** ______________________________

Father's Business Phone # ____________________ **Father's Email** ______________________________

Address (if different from above) ____

Mother's Name _______________________________ **Mother's Cell#** ______________________________

Mother's Business Phone # ___________________ **Mother's Email** ______________________________

Address (if different from above) ____

PHYSICIAN'S INFORMATION

Doctor's Name ____

Address ____

City ____ **State** ______________ **Zip Code** ______________

Office Telephone Number ___________________________ **Fax Number** ___________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: ☐May pick my child up from school ☐May **NOT** pick my child up from school

Full Name ____

Address ____

City ____ **State** ______________ **Zip Code** ______________

Home Phone _________________________________ **Cell Phone** __________________________________

Emergency Contact #2: ☐May pick my child up from school ☐May **NOT** pick my child up from school

Full Name ____

Address ____

City ____ **State** ______________ **Zip Code** ______________

Home Phone _________________________________ **Cell Phone** __________________________________

SIGNATURE OF PARENT/GUARDIAN __________________________________ **Date** _________________

Dear Parent/Guardian:

Due to HIPAA regulations, your child's Physician, Nurse Practitioner or Physician's Assistant is unable to release information about your child to anyone but yourself or anyone you designate to receive this information.

By signing the HIPPA RELEASE FORM below, you allow the Pierce Country Day School to contact your child's health care provider should we have any questions concerning medications, or if any questions, issues or concerns arise pertaining to your child's health.

Thank you.

HIPPA RELEASE FORM

Dear Health Care Provider: ______________________________________
(Name of Physician)

I, ____
(Parent/Guardian)

Parent/Guardian of ____

give permission for you to consult with and release information to:

the PIERCE COUNTRY DAY SCHOOL
37 MINEOLA AVENUE, ROSLYN, NY 11576

so that they can provide safe and appropriate care to my child concerning his/her medications and health care or if any questions, issues or concerns arise pertaining to my child's health.

Signature of Parent/Guardian: ______________________________________

Date: ____