

THE WILSON SCHOOL



MOUNTAIN LAKES, NJ 07046

INTERVAL HEALTH RECORD

NAME _____ DATE _____

ADDRESS _____ TELEPHONE NO. _____

PHYSICIAN'S NAME _____ TELEPHONE NO. _____

FATHER'S BUSINESS ADDRESS _____ TELEPHONE NO. _____

MOTHER'S BUSINESS ADDRESS _____ TELEPHONE NO. _____

PERSON TO CALL IF PARENTS AREN'T AVAILABLE:

1. NAME _____ TELEPHONE NO. _____

2. NAME _____ TELEPHONE NO. _____

Parental Permit

The law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except in an extreme emergency, without parents being contacted and fully informed.

"I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my child."

Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

Following information applies only to interval between original health card and date of this exam.

DISEASES:

OPERATIONS:

IMMUNIZATIONS (New or booster, including Mantoux testing):

CURRENT MEDICATIONS (Name, dosage, etc.)

Glasses: Reading Constantly Contact Lenses

PHYSICAL EXAMINATION:

SCOLIOSIS:

Abnormal physical findings:

I certify that I have examined _____ Grade _____
within the past six months and find him/her to be in good health, and capable of engaging in all of the academic and athletic activities of school, including swimming and a regular sports program.

He or She may take part in all school activities. If not, please give reasons:

RECOMMENDATIONS:

Date _____, MD.