CINCINNATI COUNTRY DAY SCHOOL

6905 GIVEN ROAD, CINCINNATI, OHIO 45243
SUMMER PROGRAMS: (513)979-0132; FAX: (513)527-7602

STUDENT MEDICAL RECORD FORM

This form is **REQUIRED** and must be completed and signed by a physician for all non-CCDS students attending day camp or athletic courses. This form must be on file prior to the first day of attendance.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Name: (First) (Middle) (Last)

Date of Birth:	Gender: M F	Entering Grade:
Date of last physical exam:	Physician name:	
	Physician address:	
	Physician phone:	

Day Campers should attach current immunization records.

Please check the appropriate boxes and provide details as needed in the box below.		Yes	No
1.	Does this student have any drug, food, or environmental allergies? Action Plan : Yes_____ No_____		
2.	Has this student ever had any hospitalizations, surgery, injuries, or serious medical illnesses?		
3.	Does this student have any chronic physical problems?		
4.	Are there any physician-recommended physical limitations regarding participation in athletic activities?		
5.	Is there any history of syncope or loss of consciousness during physical activity?		
6.	Does this student have any communicable diseases?		
7.	Requires regular or emergency medications, such as, but not limited to, an Epipen, Diastat, or Inhaler. If yes, please specify below.		
8.	Are any medications, food, fluoride supplements, or dietary restrictions currently prescribed? If yes, please specify below.		
9.	Has this student lived in the US for 5 years or less? If yes, please specify which country(s) they have resided in below.		
10.	Has your child had a tetanus shot? If yes, please provide date:		

Details:

If you answered yes to any of the above questions, Summer Programs may contact you should additional forms be required.

I certify that I have on this date examined this student. On the basis of this examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason that would make it medically inadvisable for this student to complete in supervised athletic activities, except as noted above. I certify that the student is free from communicable disease.

Signature of Physician (REQUIRED): _____

Print or Stamp Address and Phone

Print Name: _____ Date (REQUIRED): _____