



STUDENT HEALTH FORM  
 RYE COUNTRY DAY SCHOOL | Summer Session 2022



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**Part A**

Instructions: This form is required to complete your registration and is required for ALL students, including RCDS students.  
 This form must be completed and signed by a parent or guardian, not the student applicant.

Students from schools other than RCDS must accompany this health form with up-to-date immunization records, including COVID vaccination.  
 Current and incoming (new students in 2022-2023) RCDS students should ensure immunization records are up-to-date in the student's Magnus account.

**STUDENT INFORMATION**

Student: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_  
 (Last Name) (First Name- No Nicknames)

Current RCDS Student: Yes No  
 Incoming RCDS Student: Yes No Gender: \_\_\_\_\_ Grade completed in June: \_\_\_\_\_  
 If no to both, please attach immunization records.

**PARENT/GUARDIAN INFORMATION**

**PARENT/GUARDIAN 1**

**PARENT/GUARDIAN 2**

(Optional. Only provide info different from Parent/Guardian 1.)

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Email: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Please provide information for an additional person we may contact in the event of an emergency and the parent(s)/guardian(s) listed above are unable to be reached.

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Phone number: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

**HEALTH HISTORY**

(Please check all that apply. Please attach note if more space for details/explanation is needed.)

Illness: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 \_\_\_ Asthma (carries inhaler? Y/N \_\_\_) \_\_\_ Hay Fever \_\_\_ Other drugs: \_\_\_\_\_  
 \_\_\_ Diabetes (carries insulin? Y/N \_\_\_) \_\_\_ Insect stings \_\_\_ Other allergies: \_\_\_\_\_  
 \_\_\_ Seizures \_\_\_ Penicillin \_\_\_\_\_

Details regarding any of the above: \_\_\_\_\_  
 Other chronic or recurring illness of which the school should be aware: \_\_\_\_\_

**MEDICATIONS**

If your child requires medication – either prescription (including EpiPens) or over-the-counter medications (including Acetaminophen, Benadryl, or Ibuprofen) – during school hours, it must be administered by the School Nurse.

In order to administer this medication, the Nurse must have a completed doctor's order (See next page, Part B).

Does your child require medication during Summer Session hours? Please Check: Yes  (Please list below and complete Part B) No

Medication(s) Taken (List) : \_\_\_\_\_  
 Details regarding these medications: \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

I do hereby give authority to RCDS Summer Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible and for the nurse to administer medications provided with a doctor's order.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship: \_\_\_\_\_

*Please remember: NON-RCDS students MUST accompany this form with an up-to-date immunization form & COVID vaccination documentation. RCDS students, current and incoming, must have documentation completed and up-to-date in the Magnus system.*

**Part B**

Complete this form *only if your child requires medication* to be administered by the school nurse.  
(For further clarification, see the Medications section of Part A.)

**AUTHORIZATION FOR SCHOOL NURSE TO ADMINISTER MEDICATION  
AT RYE COUNTRY DAY SCHOOL**

**To Be Completed by the Parent/Guardian**

To: Rye Country Day School

From: \_\_\_\_\_  
(Parent's/Guardian's Name – please print)

Phone: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Grade Completed in June: \_\_\_\_\_

*I hereby give permission for the School Nurse to administer medication as directed by my child's physician.*

Parent's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**To Be Completed by the Physician**

To: Rye Country Day School

From: \_\_\_\_\_  
(Physician's Name – please print)

Phone: \_\_\_\_\_

\_\_\_\_\_  
(Child's Name – please print)

is to \_\_\_\_\_  
receive (Medication)

\_\_\_\_\_  
(Dosage & Frequency)

\_\_\_\_\_  
(Duration)

\_\_\_\_\_  
(If p.r.n., signs and symptoms for administering medication)

\_\_\_\_\_  
(Possible side effects)

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**IMPORTANT NOTE:** Prescription medication to be administered must be in a PRESCRIPTION BOTTLE with the name of the child, the name of the medication, the name of the doctor, and pharmacist's label thereon.