



THE GREENWOOD SCHOOL

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Student's Name _____ Date _____

Please list all prescription medications which your child is currently taking or has taken in the past year. Please do not include antibiotics.

Medication	Dose	Frequency

Please list all injuries and illnesses of your child which have required medical treatment, long-term therapy or hospitalizations.

Allergies medications, environment, food or insects. Indicate whether your child requires an Epi-pen for treatment.

Has your child's physical activity been restricted at any time in the last five years?

Has your child ever received professional counseling or therapy? If so, please give a brief explanation, the dates seen, and provide the name and contact information of the professional.

International students please provide a preliminary list of immunizations and attach the list to this form.

I declare that the above listed information is true and complete and that I have not withheld any information

Parent Signature _____

PRELIMINARY HEALTH FORM