Health and Immunization Record

- This form is to be **completed and signed by your child's doctor**.
- All forms need to be returned to the preschool office before your child may start school.

Child's name _____ **Male / Female**

Address _____

Birth date _____/_____/_____

Physician's name _____ **Phone #** _____

Date of last examination _____ Height _____ Weight _____ BMI _____

Is there any condition requiring special attention by the school? Yes No
If Yes, please be specific _____

Do you consider the child physically capable of participating fully in all preschool activities? Yes No **If No**, please detail all restrictions completely _____
_____

Does the child have any of the following?

Food allergies: Yes No **If Yes**, please specify the problem clearly_____
_____

Other allergies: Yes No **If Yes**, please specify the problem clearly_____
_____

Sight impairment: Yes No **If Yes**, please specify the problem clearly_____
_____

Hearing impairment: Yes No **If Yes**, please specify the problem clearly_____
_____

Asthma: Yes No **If Yes**, please specify the problem clearly_____
_____

Any Medication Taken Regularly: Yes No **If Yes**, medication name and what is it taken for _____

Any Chronic Diseases: Yes No **If Yes**, please specify clearly_____
_____

Physician's Signature _____
Date _____

Please note: New York State Public Health Law , section 2164 **mandates** that all schools shall not permit a child to be admitted unless the parent or guardian provides the school with an up to date certificate of immunizations.

Your physician may attach their record of immunization or fill in the form below.

Child's name _____

Birth date _____/_____/_____

DTP, DT, Or TD (3+) _____ _____ _____ _____ _____

Polio (3+) _____ _____ _____ _____ _____

Measles (1) _____ Mumps (1) _____ Rubella (1) _____

HIB (1+) _____ _____ _____

HEP B (3) _____ _____ _____

Tetanus (3) _____ _____ _____

Pertussis (3) _____ _____ _____

Varicella (1) _____ Pneumococcal (1+) _____

Lead Screening _____ Other (specify) _____

Any medical exemptions? Yes No **If Yes**, please explain in detail_____

_____

_____

Print, type or stamp physician's name

_____ _____

Physician's Signature **Date**