



Health and Immunization Record

This form is to be completed and signed by your child's doctor.

**All forms need to be returned before your child may start school in September.*

Child's name _____ Sex _____ D.O.B. _____
Address _____
Physicians name _____ Telephone _____

Please note: New York State REQUIRES all children entering school to have an up to date record of immunizations.

DTP, DT, Or TD (3+) _____

Polio (3) _____

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

HIB (1+) _____

HEP B _____

Lead Screening _____ Varicella _____ Other _____

Does the child have any of the following? If yes, please specify the problem clearly.

Allergies _____

Sight Or Hearing Problem _____

Asthma _____

Cerebral Palsy _____ Other Chronic Diseases _____

Any Medication Taken Regularly _____

Is there any condition requiring special attention by the school?

If yes, please be specific. _____

Do you consider the child physically capable of participating fully in all preschool activities? _____

If no, please detail all restrictions completely _____

Physician's Signature _____ Date of last examination _____