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**