

# GARDEN CITY NURSERY SCHOOL HEALTH AND IMMUNIZATION RECORD

CHILD'S NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PARENT'S NAMES: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SEX: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_

CLASS \_\_\_\_\_

**A Physical exam shall not be more than 12 months old at the beginning of the school year. Therefore, in September 2019, Physical Exams dated after September 2018 will be acceptable to meet this requirement.**

### Health Specifics

**If Yes, please provide additional information**

|  |  |  |
|--|--|--|
| Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| Medication Taken Regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| Special Diet Required? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| Medication Taken Regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| Any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |

Date of Physical Exam \_\_\_\_\_

Date of most recent Vision Screening \_\_\_\_\_

Findings \_\_\_\_\_

Date of most recent Hearing Screening \_\_\_\_\_

Findings \_\_\_\_\_

Summary of Physical Exam – Include special recommendations for nursery school

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On the basis of my findings as indicated above and on my knowledge of the named child, I find that he/she is free from contagious and communicable disease and is able to participate in nursery school.

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please Print Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Immunization report on below – Any new student must submit proof of immunizations BY FIRST DAY OF SCHOOL.**

# IMMUNIZATIONS

New York Public Health Law 2164 requires all children entering and attending a preschool program to demonstrate proof of immunity against diphtheria, polio, measles, mumps, rubella, and haemophilus influenza type b (Hib), varicella (for children born on or after 1/1/2000), pneumococcal (for children born on or after 1/1/08).

**STUDENTS WILL NOT BE ADMITTED TO SCHOOL IF IMMUNIZATION REQUIREMENTS ARE NOT MET UNLESS A RELIGIOUS OR MEDICAL EXEMPTION HAS BEEN PROVIDED.**

CHILD'S NAME: \_\_\_\_\_

| VACCINE                       | Date of Administration |          |          |                       |         |
|-------------------------------|------------------------|----------|----------|-----------------------|---------|
|                               | 1st dose               | 2nd dose | 3rd dose | 4th dose<br>(Booster) | Booster |
| DPT/DT                        |                        |          |          |                       |         |
| Polio                         |                        |          |          |                       |         |
| HIB                           |                        |          |          |                       |         |
| Hepatitis B                   |                        |          |          |                       |         |
| (Measles-Mumps-Rubella) (MMR) |                        |          |          |                       |         |
| (Varicella) Varivax           |                        |          |          |                       |         |
| Pneumococcal                  |                        |          |          |                       |         |

## Tests

Tuberculin Test Date: \_\_\_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm  
 TB Tests are at the physician's discretion.  
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_\_\_ Attach lead level statement.

## Religious Exemptions

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization. Do you wish to exercise those rights?  Yes  No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak. The child may return only upon approval of the local county health department.

\_\_\_\_\_  
 Signature of parent or person legally responsible Date

## Certification from Physician:

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_