

GARDEN CITY NURSERY SCHOOL HEALTH AND IMMUNIZATION RECORD

CHILD'S NAME: _____
 ADDRESS: _____
 PARENT'S NAMES: _____

DATE OF BIRTH: ____/____/____
 GENDER: _____
 TELEPHONE: _____

CLASS _____

A Physical exam shall not be more than 12 months old at the beginning of the school year. Therefore, in September 2021, Physical Exams dated after September 2020 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

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 JULY 1.

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 MEDICAL EXEMPTION HAS BEEN PROVIDED.

CHILD'S NAME: _____

VACCINE	Date of Administration				
	1st dose	2nd dose	3rd dose	4th dose (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.

Exemptions

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: ____/____/____