GARDEN CITY NURSERY SCHOOL
HEALTH AND IMMUNIZATION RECORD

CHILD'S NAME: _____ DATE OF BIRTH: _____/_____/_____
ADDRESS: _____ SEX: _____
PARENT'S NAMES: _____ TELEPHONE: _____

CLASS _____

A Physical exam shall not be more than 12 months old at the beginning of the school year. Therefore, in September 2020, Physical Exams dated after September 2019 will be acceptable to meet this requirement.

Health Specifics

	If Yes, please provide additional information
Allergies? □ Yes □ No	
Medication Taken Regularly? □ Yes □ No	
Special Diet Required? □ Yes □ No	
Medication Taken Regularly? □ Yes □ No	
Any hearing, visual or dental conditions requiring special attention? □ Yes □ No	
Any medical or developmental conditions requiring special attention? □ Yes □ 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 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 diptheria, 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

<u>Certification from Physician:</u>

Physician's Signature: _____ **Date:** _____/_____/_____