St. Mark’s Cooperative Nursery School



100 HEMPSTEAD AVE., ROCKVILLE CENTRE, NEW YORK 11570

Phone: 516-536-6295 Fax: 516-763-5141

**FORM #2 – HEALTH RECORD**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***This section to be filled in by physician:***

**DATE OF LAST PHYSICAL EXAM**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Required for State compliance)***

**IMMUNIZATION RECORD: *(Required for School Attendance – Please fill out or attach your own vaccination record)***

Dose # 1 Dose # 2 Dose # 3 Dose #4

DPT (Diphtheria, Pertussis, Tetanus) \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

TOPV (Trivalent Oral Polio Vaccine) \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

MMR (Measles, Mumps, Rubella) \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

HIB (Haemophilus Influenza Type B) \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

Hepatitis B \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

Chickenpox Vaccine (Varicella) \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

Pneumococcal \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_ \_\_/\_\_/\_\_

Blood Lead Level Test: Y \_\_\_N \_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant History (Indicate Year)

Allergies(List):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convulsive Disorders:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious Illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications Currently Taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FORM #2 – HEALTH RECORD (cont'd)**

Examine and Complete: Is hearing within normal limits? Y\_\_\_ N\_\_\_\_

Is vision within normal limits? Y\_\_\_ N\_\_\_\_

Are teeth within normal limits? Y\_\_\_ N\_\_\_\_

Are there any physical or emotional problems, which the school should be aware of? If yes, please detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have examined this child and in my opinion he/she is in good physical condition and able to participate in the nursery school’s activities.**

PHYSICIAN’S SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Physician should affix stamp)*

ADDRESS/TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*IF YOUR CHILD HAS FOOD ALLERGIES\*\***

If your child has any **food allergies**, please continue on to the next forms and complete in full. You do NOT have to fill out the Allergy Action Plan if your child does **NOT** have any food allergies.

The “**FOOD ALLERGY ACTION PLAN**” along with the “**INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN**” and the “**INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS**” must be filled out in its entirety and properly signed by you and your child’s physician or allergist. A photograph of your child is required in the upper right hand corner of the Food Allergy Action Plan.

These forms must be submitted before the first day of school. Please send in

any medications prescribed by your physician on the Allergy Action Plan

prior to the first day of school but not later than the first day of school.

Medications must be labeled with your child's name and dosing instructions.

must also appear on prescription medications.