ST MARK'S 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 list Month/Day/Year 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:_____

(continues on reverse →)

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 any food allergies, please continue on to the next page and complete the "Food Allergy Action Plan". 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" 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.

This form 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.