

# OUR REDEEMER NURSERY SCHOOL STUDENT HEALTH FORM

2025 Washington Avenue Seaford, NY 11783 516-781-7637

New York State Regulations require that prior to admission to school, each child shall have a completed physical examination by a physician, including an *appropriate vision screening, audio testing, laboratory tests as indicated and a dental examination*. A written statement signed by the examining physician shall be furnished to the school. *All children shall have a yearly physical examination by a physician and a dental examination by a dentist. This form shall be submitted to the school by September 1.*

If your child's well visit is scheduled after September 1, then furnish us with a copy of your child's most current immunization records by FAX, (516) 781-6374 or mail by September 1. Please submit the health form as soon as possible after your child's well-visit.

**\*EXAM IS TO BE COMPLETED BY A LICENSED PHYSICIAN, A PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER**

## PART 1

Date of Exam \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

## CHILD'S HEALTH RECORD

Has the child had any serious illness, hospital stay or operation? If YES, please explain:

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

**Is the child subject to any of the following:**

Allergies (Specify) \_\_\_\_\_

Asthma \_\_\_\_\_ Seizures \_\_\_\_\_

Medication (Specify if other than vitamins) \_\_\_\_\_

## TESTS

VISION \_\_\_\_\_ HEARING \_\_\_\_\_

DATE OF LEAD SCREENING EXAM \_\_\_\_\_

**Attach Lead Level Statement (Include All Dates & Results)**

1 Year     /     /     Result     mcg/dL  Venous  Capillary

2 Years     /     /     Result     mcg/dL  Venous  Capillary

Most recent date of lead screening (if different from above):

    /     /     Result     mcg/dL  Venous  Capillary

(OVER)

**NEW YORK STATE IMMUNIZATION REQUIREMENTS FOR ENTRY INTO PRE-SCHOOL**

**List dates vaccine administered below:**

(3 doses) Diptheria, Tetanus and Pertussis(DPT) \_\_\_\_\_

(3 doses) Diptheria and Tetanus and acellular Pertussis (DTaP) \_\_\_\_\_

(3 doses) Polio (IPV or OPV) \_\_\_\_\_

(1 dose) Measles, Mumps, Rubella (MMR)6 \_\_\_\_\_

(3 doses) Hepatitis B \_\_\_\_\_

(4 doses) Haemophilus influenza type b (Hib) \_\_\_\_\_

(4 doses) Pneumococcal Conjugate Vaccine (PCV) \_\_\_\_\_

(1 dose) Varicella (Chickenpox)6 \_\_\_\_\_

**Summary of Physical Exam** (Include any additional info that may be helpful for this child’s teachers to be aware of.)

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

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\_\_\_\_\_  
Signature of examiner

\_\_\_\_\_  
Address

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

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**The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_ (date of exam)**  
**The date of the exam needs to be within 12 months of the start of the school year in which it is requested.**

**Check one:**

\_\_\_\_\_ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at nursery school.

\_\_\_\_\_ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the nursery school.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the nursery school does not preclude the student from attending school.

Dentist’s Name and Address \_\_\_\_\_

Dentist’s Signature \_\_\_\_\_