NORTH SHORE NURSERY SCHOOL 90 Plandome Road Manhasset, NY 11030
Telephone: 516-365-7244 Fax: 516-869-5788

HEALTH RECORD

DATE OF EXAM_____

Child's Name_____Telephone #_____

Address_____

Birthdate_____Sex_____Height_____Weight_____

Immunization Record (Required for School Attendance - Please list Month, Day, Year)

	Dose #1	Dose #2	Dose #3	Dose #4
DPT (Diphtheria, Pertussis, Tetanus)	_/_/_	_/_/_	_/_/_	_/_/_
OPV/IPV (Polio Vaccine)	_/_/_	_/_/_	_/_/_	_/_/_
Hepatitis B	_/_/_	_/_/_	_/_/_	_/_/_
HIB (Haemophilus Influenza Type B)	_/_/_	_/_/_	_/_/_	_/_/_
MMR (Measles, Mumps, Rubella)	_/_/_	_/_/_	_/_/_	_/_/_
Pneumococcal	_/_/_	_/_/_	_/_/_	_/_/_
Chickenpox Vaccine (Varicella)	_/_/_			
Lead Screening	_/_/_	_____		

Significant History (Indicate Year) ---- MUST BE COMPLETED---

Allergies (List):_____Foods:_____

Medication:_____Treatments:_____

Convulsive Disorders:_____

Medication:_____

Serious Illness:_____

Infectious Disease:_____

Operations:_____

Medications Currently Taking:_____

Other:_____

Examine and Complete: Is hearing within normal limits?_____

Is vision within normal limits?_____

Are teeth within normal limits?_____

Are there any physical or emotional problems, which the school should be aware of? If yes, please detail on back._____

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

PHYSICIAN'S SIGNATURE_____

ADDRESS_____

TELEPHONE_____Physician should affix stamp