Plainview Nursery School Health Record

Parents: Please complete:

Child's Name _____ Birth Date _____ Child's Class _____
Address _____ Telephone _____

Family Physician in case of Emergency: _____
Telephone Number: _____
Relative/Friend to call in case of Emergency: _____
Telephone Number: _____

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Examining Physician: Please complete **Date of Examination:** _____

Heart _____ Lungs _____ Abdomen _____
Extremities _____ Skin _____ Nose _____
Eyes _____ Ears _____ Head _____
Throat _____ Mouth _____ Hands/Feet _____

Health Specifics:

Heart Murmur _____ Orthopedic _____
Vision _____ Hearing _____
Other Medical or Developmental Conditions requiring special attention _____
_____
Allergies (describe) _____
Is special diet required? (Specify diet and conditions) _____
_____
Is medication taken on a regular basis? (Specify drugs and condition) _____
_____
Operations _____
Childhood Diseases _____

Immunizations: Give all dates of each Immunization

DTP				
IPV				
Hep B				
HIB				
MMR				
Varicella				
Prevnar				
Lead Screening				
Tuberculin Testing	Date:	Results:		

Medical Exemption:
The physical condition of the above named child is such that immunization would endanger life or health.

_____ _____
Signature of Examining Physician Date

_____ Address: _____
Signature of Examining Physician

_____
Date Telephone _____

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