My First School
A Cooperative Experience

35 Verbena Ave., Floral Park, NY 11001 myfirstschoolfp.org 516.354.0138 **FAX 516.354.6215**

Health Record

Name of Child_____ **Date of Birth**_____

Physician's Name, Address, Phone _____

(Please give full address) _____

THE FOLLOWING INFORMATION MUST BE COMPLETED AND SIGNED BY PHYSICIAN:

Dates of Past Illnesses:					
Anemia	Chickenpox	Heart Disease	Measles	Rheumatic Fever	Scarlet Fever
Diabetes	Epilepsy	Mumps	Rubella	Asthma	Ear Conditions
Operations/serious injuries				**Allergies**	

Dates of Preventative & Control Measures: Please fill in all dates(THIS MAY BE FAXED OVER BY DR. OFFICE) 516.354-6215

Polio (IPV) _____ _____ _____ _____ Tuberculin Test (PPD) _____ HIB_____ _____ _____ _____ Prevnar _____ _____ _____ _____	DTaP _____ _____ _____ _____ MMR _____ _____ Varicella (Chicken Pox) _____ Hepatitis B _____ _____ _____
Eyeglasses: yes_____ no_____ Weight _____ Height _____	Urine Analysis_____ Blood Pressure_____

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Nutrition			Nervous System			Heart		
Eyes			Speech			Lungs		
Ears (otoscopic)			Teeth			Abdomen		
Lymph Nodes			Orthopedic:			G.I.		
Thyroid			Structural			Feet		
Nose			Scoliosis			Skin		
Tonsils			Posture					

General Health: _____ Allergies: _____

Date of exam:_____ Physician's Signature:_____

*** We will accept a signed & dated photocopy of your child's last well child exam listing medical clearance for school & a copy of their full immunization record from your physician in lieu of this form.**