

MEDICAL HEALTH FORM Required for Grades, 2, 4 and new entrants. Failure to return this medical report will result in the school physician examining your child.

NAME _____ **GRADE** _____

Date of Birth _____ Age _____ Male Female

PARENT'S NAME (or Guardian)

Mother _____
Name _____

Phone/Home _____ Business _____ Beeper/cell _____

Father _____
Name _____

Phone/Home _____ Business _____ Beeper/cell _____

PHYSICIAN to be called in emergency:

Name _____ Phone _____

PERSON other than parent to be called in emergency:

Name/Relationship _____ Phone _____

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies _____	Heart Disease _____
Anemia _____	Kidney Disease _____
Asthma _____	Mononucleosis _____
Chicken Pox _____	Pneumonia _____
Congenital Defect _____	Seizure Disorder _____
Diabetes _____	Strep/Scarlet Fever _____
Ear Condition _____	Other _____

DATES AND DESCRIPTIONS

Operations _____
Serious Injuries _____

IMMUNIZATIONS – Given this calendar year (TO BE COMPLETED BY PHYSICIAN)

Initial Series	Measles _____
DPT 1st _____	Mumps _____
2nd _____	Rubella _____
3rd _____	MMR #1 _____
1st _____	MMR #2 _____
2nd _____	Polio 1st _____
Tdap _____	2nd _____
	3rd _____
HEP. B _____	Boosters: _____
	TB (PPD) _____
	Results _____
Varicella 1st _____	HIB _____
2nd _____	Hep A _____

TO BE COMPLETED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN NEW YORK STATE

Resting Pulse* _____

Blood Pressure* _____ / _____ Eyes _____

BMI _____ Weight Stat. Cat _____ %

Height* _____ Weight* _____

Lymph Nodes _____ Thyroid _____

Nose _____ Tonsils _____

Heart _____ Lungs _____

Hernia _____ Genito-urinary _____

Ortho-Struc. _____ Scoliosis _____

Feet _____ Skin (non-comm.) _____

Seizure Disorder _____ Other _____

Defects (specify) _____

Recommendations _____

Vision R.20/ _____ L.20/ _____

W/Glasses R20/ _____ L20/ _____

W/Contacts R20/ _____ L20/ _____

STUDENT CAN PARTICIPATE IN ALL SCHOOL ACTIVITIES AND INTRAMURALS WITHOUT RESTRICTIONS.

() Restrictions(s) (Requires doctor's letter)

Physician's Signature _____

Physician's Name Printed _____

Physician's Address _____

_____/_____/_____

DATE OF EXAM* _____ Phone Number _____

MAIL TO: HEALTH OFFICE
HARBOR HILL SCHOOL
03 GLEN COVE ROAD
GREENVALE, NY 11548