

**MEDICAL HEALTH FORM** Required for Grades Pre K, K, 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 (TO BE COMPLETED BY PHYSICIAN)**

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

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

Resting Pulse\* \_\_\_\_\_

Blood Pressure\* \_\_\_\_\_ / \_\_\_\_\_ Eyes \_\_\_\_\_

BMI \_\_\_\_\_ Wieght Status 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 R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

W/Contacts R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

**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  
HEIGHTS SCHOOL  
WILLOW STREET  
ROSLYN HGTS., NY 11577