IMPORTANT NOTICE

PLEASE HAVE MEDICAL DOCTOR/PEDIATRICIAN FILL OUT BOTH PAGES OF SCHOOL MEDICAL/PHYSICAL ***FORM DUE SEPTEMBER 7, 2011 - FIRST DAY OF SCHOOL*** REQUIRED BY NEW YORK STATE LAW AND SCHOOL POLICY.

1. A COPY OF THE IMMUNIZATION RECORD MUST BE BROUGHT TO REGISTRATION. TRANSFER STUDENTS MUST ALSO SUBMIT IMMUNIZATION RECORD. (PLEASE NOTE: WE CANNOT MAKE COPIES AT THIS TIME.)

2. A COPY OF COMPLETE PHYSICAL EXAMINATION, DATED 2010, MUST BE BROUGHT TO SCHOOL BY SEPTEMBER 7, 2011

It is advisable that you make your appointment now in order to meet the September 7th due date.

3. If student is entering New York City School System for the **first time**, a **Tuberculosis** (PPD or Mantoux) skin test is required with test **date** and **results**.

4. All Immunizations/boosters must be up-to-date. Include record of Varicella (chicken pox) immunization or date of illness - due September 7, 2011

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NY State law requires the following immunizations for admission to school: 3 doses Diphtheria (DPT, DT or TD); 3 doses Polio (IPV) or 3 doses Polio (OPV); 2 doses Measles, 1 dose Mumps, 1 dose Rubella; 3 doses Hepatitis B Series, 1 dose Varicella (chicken pox) or indication of history of illness.

Medical or religious exemptions are acceptable if written proof is presented at the time of school registration. A medically documented history of disease for measles, mumps, rubella or varicella is also acceptable. Such histories or exemptions should be written in the space for dates.

PLEASE BE SURE ALL SECTIONS ARE COMPLETED BY YOUR PHYSICIAN.

All Information On This Form Should Be Up-To-Date. This Physical Is Required By Law.

MEDICAL REPORT (To be completed by Physician)

Current Health Status/Diagnosis/Medications:

Physical Examination: (List all abnormal findings whether handicapping or not)

Weight: Height: Blood Pressure:

CURRENT MEDICATIONS:

SCREENING TESTS (Please record if done within the past year) (NOT REQUIRED)

Vision:
Near: with glasses R ______ L ______
without glasses R ______ L ______
Far: with glasses R ______ L ______
without glasses R ______ L ______
Fusion:
___ Pass
___ Fail

Hearing: (Audiometric Screen)

Sweep: ___ Pass ___ Fail Threshold: ___ Pass ___ Fail

Hemoglobin ______________ Or Hematocrit ______________

Micro Lead __________ mg/100 ml
Venous Lead__________ mg/100 ml
VDRL ______________________
MISC. ______________________

Mantoux Test (Only if needed) If Positive, give X-ray findings Date

___ Negative ___ Positive

Urinalysis:
Sugar ______________ Protein ______________ Other ______________

Follow-up (Referrals for Follow-up appointments made):

Recommendations for Physical Activity in School:

___ Full Physical Activity

___ Modified Physical Activity (Specify) ______________________

___ Specific Physical Activity Contraindicated ______________________

___ Special recommendations or modifications in pupil's program ______________________

Signature of Physician Date of Exam.

Print or Type Name of Physician:

Address City Zip Telephone No.

Name (Last) (First)	Date of Birth	Male ____ Female ____ Check One
Name of Parent or Guardian (Last) (First)	Relationship to Child	

Street Address (with Apt. #) City Zip	Telephone Home: Work:

Name/# of School	Borough	Grade/Class	Language Spoken at Home

HEALTH HISTORY (To be completed by the Parent)

Health Problems/Diagnosis:

Current Medications:

Has child had or does child now have any of the following conditions?

___ Chicken Pox
___ Measles
___ Mumps
___ Rubella (German Measles)
___ Allergies (specify)
___ Frequent colds or sore throats
___ Ear Infections
___ Trouble Hearing
___ Bronchitis or ___ Asthma
___ Convulsions
___ Rheumatic Fever
___ Heart Trouble
___ Orthopedic Problem
___ Tuberculosis
___ Eye or Vision Problem
___ Speech Problem
___ Urinary Tract
___ Intestinal Parasites

___ Serious Illness (Specify and give dates)

___ Operations (Specify and give dates

___ Serious Accidents (Specify and give dates)

___ Other problems or handicapping conditions (Specify)

___ Is child now under regular medical care? Name of doctor, hospital or clinic:

Address:

___ Menstrual problems (cramps, nausea, heavy bleeding, backache)

IMMUNIZATION HISTORY *(To be completed by Physician or Health clinic)*

DPT or DT or TD ____ Date ____ Date ____ Date ____ Date ____ Date

Polio (OPV; Sabin) ____ Date ____ Date ____ Date ____ Date ____ Date

Polio (IPV; Salk) ____ Date ____ Date ____ Date ____ Date ____ Date

Hepatitis B Series ____ Date ____ Date ____ Date

**Measles ____ Date ____ Date

**Rubella ____ Date ____ Date

**Mumps ____ Date ____ Date

Varicella ____ Date

**Given after first birthday.

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