MEDICAL RECORD – 2021-2022

CHILD'S WORLD NURSERY SCHOOL
35 Middle Neck Road, Port Washington, NY 11050
*Phone **516-883-4141** - FAX **516-883-4702***

Student Name___________________________

Date of Birth ___________________________

EMERGENCY CONTACTS:

Parent Name____ Cell #_______________________ Work #______________________

Parent Name____ Cell #_______________________ Work #______________________

Home Phone #________________________ Health Insurance Carrier & Number____

If not available in an emergency please notify: (two names are required)

1.____ ____________________ ______________________________
Name Tel. # Relationship to Child

2.____ ____________________ ______________________________
Name Tel. # Relationship to Child

TO BE COMPLETED BY CHILD'S PHYSICIAN:

Vision Screening-Results________________Date_________ Hearing Test-Results_______________Date_________

Record of Immunizations/Vaccinations Required for School Attendance:
In accordance with New York State Public Health Law 2164, this record, signed by a physician and listing exact dates, must be on file the first day of school. **STUDENTS WILL NOT BE ADMITTED TO SCHOOL IF IMMUNIZATION REQUIREMENTS ARE NOT MET.**

Minimum 3 Full Dose Dates:

DPT or DT (circle) 1.__________________ 2.__________________ 3.__________________ Booster____________________

Polio TOPV 1.__________________ 2.__________________ 3.__________________ Booster____________________

Pneumoccal (PCV) 1.__________________ 2.__________________ 3.__________________ Booster____________________

Hep B 1.__________________ 2.__________________ 3.__________________

HIB 1.__________________ 2.__________________ 3.__________________
(Or 1 dose if administered on or after 15 months of age)

Live Vaccine On or After 1st Birthday:

MMR__________________________________ TB Test ____________________________________

Measles_______________________________ Chicken pox__________________________________
(Second dose at 4-6 yrs. of age required for KINDERGARTEN)

Mumps________________________________ Lead Screening________________________________

Rubella_______________________________

WAIVER: (attach statement) ____

Does child have any allergies? __________________ Please list: ____

Does child have a physical handicap? ____

Do you know of any special needs with which the nursery school could help the child? ___________________________

Please list any other pertinent information regarding the child's health history, e.g., surgery, chronic illness, etc.__________________
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Child was examined on ______________________ and was found to be in good general health, free of communicable diseases and may attend day care and participate in all activities.

____ ____
Signature: Examining Physician *Physician Phone Number*

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Physician Name and Address