

North Shore Early Childhood Center, Inc.  
 440 Round Hill Road  
 Roslyn Heights, NY 11577



**Medical Examination History:**

*This side to be filled in by parent and checked with physician at the time of examination.*

Child's Last Name	First Name	Birth	Sex	Age
Parent or Guardian Last Name	First Name	Telephone		
		Cell:		
		Work:		
Home Address				
City	State	Zip		

If not available in an emergency notify:

1. Name	Telephone
Street Address	State Zip
2. Name	
Street Address	State Zip

**Health History (Check - giving approximate dates)**

**Asthma**

- Current
- Past
- Ear Infections
- Rheumatic Fever
- Diabetes

**Allegeries**

- Hayfever
- Poison Ivy, etc.
- Insect Sting
- Penicillin
- Other Drugs

**Childhood Diseases**

- Chicken Pox
- Measles
- German Measles
- Mumps

Operating or Serious Injuries (Dates)

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Chronic or Recurring Illness

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Other Diseases or Details of Above

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Any specific activities to be encouraged?

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**IMPORTANT:** Please send notification to the address shown above, if the child named on this document is exposed to any communicable disease during the three weeks prior to the beginning of school.

**Parent's Authorization :**

**Note:** Child will not be accepted into North Shore Early Childhood Center, Inc. unless the Authorization is signed.

This health history is correct and the child herein described has permission to engage in all prescribed school activities, except as noted in writing by me and the examining physician.

In the event that I cannot be reached in an emergency, I hereby authorize North Shore Early Childhood Center, Inc to use their own pediatrician, nurse, or hospital and grant permission for the doctor selected by North Shore Early Childhood Center, Inc. to hospitalize, secure proper treatment and to order injection, anesthesia or surgery for my child as named above.

Signature	Date
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OFFICE OF CHILDREN AND FAMILY SERVICES

**Medical Statement of Child in Childcare**

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
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**Immunizations required for entry into day care**

Yes  No

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)					
Polio (IPV or OPV)					
Haemophilus influenzae type B (Hib)				4 <sup>th</sup> Date OR 1 <sup>st</sup> Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08					
Hepatitis B					
Measles, Mumps and Rubella (MMR)					
Varicella (also known as Chicken Pox)					

**Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A**

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

**Tests**

Tuberculin Test Date:     /     /     Mantoux Results:      Positive    Negative     \_\_\_\_\_ mm

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date:     /     /     \_\_\_\_\_

Attach lead level statement

**Lead Screening (Include All Dates and Results)**

1 year     /     /     Result:     \_\_\_\_\_     mcg/dL      Venous      Capillary

2 years     /     /     Result:     \_\_\_\_\_     mcg/dL      Venous      Capillary

**Most recent date of lead screening (if different from above):**

\_\_\_\_\_ /     /     \_\_\_\_\_     Result:     \_\_\_\_\_     mcg/dL      Venous      Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.** If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care.   \_\_\_ YES   \_\_\_ NO

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	(     )     _____     Date

**Religious Exemptions**

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.