

# WOODSTOCK DAY SCHOOL

The New York State Educational Law requires every child to have a health examination within one year prior to his/her entrance to school and also upon entering grades kindergarten, 2nd, 4th, 7<sup>th</sup> and 10th. We ask that you take your child to your family physician and have this form completed and returned to the school by the first day of school.

**Failure to submit health form may result in your child not being able to attend school. This is state-mandated; not a Woodstock Day School option.**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Gender \_\_\_\_\_

## EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_

Skin \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Eyes \_\_\_\_\_ Lungs \_\_\_\_\_

Ears \_\_\_\_\_ Hernia \_\_\_\_\_

Nose \_\_\_\_\_ Genito-Urinary \_\_\_\_\_

Tonsils \_\_\_\_\_ Feet \_\_\_\_\_

Lymph Nodes \_\_\_\_\_ Nervous System \_\_\_\_\_

Heart \_\_\_\_\_ Speech \_\_\_\_\_

Heart Rate \_\_\_\_\_ Nutrition \_\_\_\_\_

Orthopedic (*Structure, Posture*) \_\_\_\_\_

General Condition \_\_\_\_\_

Other \_\_\_\_\_

**Medication(s)** \_\_\_\_\_

**Dosage and Frequency:** \_\_\_\_\_

## IMMUNIZATIONS

	Dates		Dates
DPT (Diphtheria-Pertussis-Tetanus)	_____	Mumps	_____
DT (Diphtheria-Tetanus)	_____	Rubella	_____
Tetanus	_____	Haemophilus Influenzae (HIB)	_____
Polio	_____	Hepatitis B	_____
Measles, Mumps, Rubella (MMR)	_____	Varicella	_____
Measles	_____	Other	_____

New York State Law requires all students to be immunized against diphtheria, measles, mumps, rubella, polio and pertussis. Students born on or after 1/1/85 must have two doses of live measles vaccines prior to entering kindergarten. Students born on or after 1/1/94 and entering 6<sup>th</sup> grade must have a varicella vaccination. Three doses of Hepatitis B are required for all students enrolled in 7<sup>th</sup> grade on or after 9/1/2000.

**PLEASE COMPLETE REVERSE SIDE OF FORM**

**PREVENTIVE MEASURES AND TESTS**

Tuberculin Test \_\_\_\_\_ Urinalysis \_\_\_\_\_ Results \_\_\_\_\_

*Results* \_\_\_\_\_ Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

Chest X-Ray \_\_\_\_\_ Distance Vision: Right \_\_\_\_\_ Left \_\_\_\_\_

*Results* \_\_\_\_\_ Color Perception \_\_\_\_\_

**The school strongly recommends that the child have a dental examination as part of his regular health care.**

**HISTORY OF PAST ILLNESS**

	Date		Date
Chickenpox	_____	Diabetes	_____
Diphtheria	_____	Loss of Consciousness	_____
German Measles	_____	Heart Disease	_____
Measles	_____	Tuberculosis	_____
Mumps	_____	Contact with TB	_____
Bladder/Kidney Disease	_____	Ear Condition	_____
Pneumonia	_____	Asthma or Allergies	_____
Speech Difficulty	_____	<i>Specify</i>	_____
Frequent Colds	_____	Other	_____

Recommendations of physician for follow-up and/or modifications of school program:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

(Please print or stamp)