THE NEW INTERDISCIPLINARY SCHOOL
430 Sills Road, Yaphank, NY 11980 * Phone: 631-9245583 * Fax: 631-9245687

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

| Name of Child: | Date of Birth: | Date of Examination: |
|---|---|---|
| | | |

### Immunizations Are Required

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

### 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

| **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 school 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. | | | | | | |

**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).

### 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 school which will then determine whether the statement of religious belief is acceptable.

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# PHYSICAL EXAMINATION

**Office use only:** ☐ SpEd ☐ UPK ☐ Nurs ☐ CC

| Child's Name: | DOB: |
|---|---|
| Exam Date: | ☐ Male ☐ Female |

## MEASUREMENTS

HEIGHT: _____ WEIGHT: _____ HEAD CIRCUMFERENCE: _____

## Exam Findings

Heart: _____ Lungs: _____

Lymph Node: _____ Abdomen: _____

Musculoskeletal: _____ Neurological: _____

Genito-Urinary: _____ Skin: _____

## History

Childhood Illnesses: _____

Surgeries: ☐ Yes ☐No _____

| Health Specifics | Comments |
|---|---|
| Are there allergies? (Specify) ☐ Yes ☐ No | |
| Is medication regularly taken? (Specify drug and condition) ☐ Yes ☐ No | |
| Is a special diet required? (Specify diet and condition) ☐ Yes ☐ No | |
| Are there any hearing, visual or dental conditions requiring special attention? ☐ Yes ☐ No | |
| Are there any medical or developmental conditions requiring special attention? ☐ Yes ☐ No | |

## Summary of Physical Exam

Include special recommendations

_____

_____

On the basis of my findings as indicated above and on my knowledge of named child, I find that: he/she is free from contagious and communicable disease and is able to participate in school/daycare. ☐ **Yes** ☐ **No**

_____ _____

**Signature of Examiner** **Date**

_____ _____

**Address** **Phone**