PHYSICAL EXAMINATION

Child's Name: _____Date of Birth: _____

Parent or Guardian Name_____

Address: _____City_____Zip_____

Home Tel:_____Work Tel:_____Cell Phone:_____

****

EXAM DATE: _____ ☐ Male ☐ Female

MEASUREMENTS

HEIGHT: _____ WEIGHT: _____ HEAD CIRCUMFERENCE: _____

EYES (visual activity)

R _____ Corrected R _____ L _____ Corrected L _____

Other Findings: _____

ENT (Otoscopic, Hearing)

_____

_____

CHILDHOOD ILLNESSES

_____

_____

_____

HEART (rate, rhythm, murmurs, BP)

_____

_____

CHEST & LUNGS

_____

_____

ABDOMEN

_____

_____

GENITO-URINARY

_____

MUSCULO -SKELETAL

SCOLIOSIS SCREENING

SKIN

NEUROLOGICAL (cranial nerves, motor & sensory function, V.P. shunt)

ANY PRESCRIBED MEDICATION

ANY PHYSICAL LIMITATIONS

DOES CHILD HAVE ANY KNOWN ALLERGIES? ☐ **Yes** ☐ **No**

HAS HE/SHE HAD SURGERY (IES)? ☐ **Yes** ☐ **No**

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Physician's Signature ***Physician's Address and Phone Number***

Date: _____

THE NEW INTERDISCIPLINARY SCHOOL

CERTIFICATE OF IMMUNIZATIONS

Child's Name:_____

Address: _____ Home Telephone:_____

Work Telephone:_____

Parent or Guardian_____

Cell Phone:_____

In accordance with New York State Public Health Law 2164, a Certificate of Immunization, MUST be signed by physician, listing exact dates, and MUST be on file on the first day of school.

*****Students will not be admitted to school if immunization requirements are not met.*****

REQUIRED FOR SCHOOL ATTENDANCE: Minimum of three (3) full dose dates.

LIST BY MONTH / DAY / YEAR	Dose # 1	Dose # 2	Dose # 3	Booster	Booster
DPT (Diptheria, Pertussis, Tetanus)	/ /	/ /	/ /	/ /	/ /
or **DT** (Diptheria, Tetanus)	/ /	/ /	/ /	/ /	/ /
TOPV (Trivalent Oral Polio Vaccine)	/ /	/ /	/ /	/ /	/ /

REQUIRED FOR SCHOOL ATTENDANCE: Live vaccine on or after first birthday. Full dates required.

(Haemophilus Influenza Type B) (3 or 1 if administered after 15 months of age)

Mumps ___/__/____ HIB Vaccine ___/__/____ ___/__/____ ___/__/____

Measles ___/__/____ HEP B ___/__/____ ___/__/____ ___/__/____

Rubella ___/__/____ Prevnar: ___/__/____ ___/__/____

___/__/____

MMR ___/__/____

Varicella ___/__/____ TB Test ___/__/____ Results: _____

(If born on or after 1/1/2000) Lead Screening ___/__/____

Legal requirements for immunizations waived because of:

- ☐ Religious exemptions (written statement attached)
- ☐ Physician's medical exemption (Physician's statement attached)
- ☐ Vaccine(s) waived: _____
- ☐ Vaccines waived due to temporary condition

  If yes, new date scheduled for immunization: _____

_____ _____

_____

Physician's Signature **Date** _____

Physician affix stamp

PERMISSION FOR TYLENOL

IMPORTANT

TO BE COMPLETED BY PHYSICIAN AND BY PARENT / GUARDIAN

I hereby prescribe the use of Children's Tylenol to be administered in the event of

an emergency to: _____ School Year_____
Child's Name

Dose Amount: _____ can be administered to the above named child by the School Nurse or an Administrator of NIS in the event that the child has a temperature of _____ degrees or over.

Physician Signature:_____Date:_____

I HEREBY APPROVE THE ABOVE ORDER

Parent/Guardian Signature_____Date:_____