SAINT JOHN'S PRESCHOOL

St. John the Baptist RC Church
1488 North Country Road
Wading River, New York 11792
(631) 929-3220 Fax (631) 929-6961

HEALTH EXAMINATION & IMMUNIZATION RECORD

Student Name: _____

Address: _____

Date of Birth: _____Height:_____ Weight:_____ Age:_____

Vision Acuity R_____ L_____ Eye Defects _____

Ears (otoscopic)_____

Lymph Nodes_____ Thyroid_____

Teeth: Temporary_____ Permanent_____

Nose_____ Tonsils_____

Heart_____ Lungs_____

Hernia_____ Genitor-Urinary_____

Structural Defect_____

Feet_____ Posture_____

Skin (non-commun) _____ Epilepsy_____

Nervous System_____ Speech_____

Nutrition_____ Other_____

Medication for any chronic condition_____

_____

Restriction on play or other physical activities_____

_____

Date of Examination_____ Physician's Signature_____

Please complete Immunization Record on reverse side.

Immunizations

DPT: 1.Date _____2. Date_____

3.Date_____4.**Date _____**

Polio: 1.Date _____2.Date _____ 3.Date _____

M/M/R: 1. Date_____

Hep. B: 1.Date_____2.Date _____3.Date _____

Varicella: 1.Date _____

HIB: 1.Date_____ 2.Date _____
3.Date _____4.Date _____

PCV: 1.Date _____ 2.Date _____
3.Date _____ 4.Date_____

Other: Date_____

Physician's Signature/Stamp

_____