ST. ELIZABETH ANN SETON REGIONAL SCHOOL

2341 Washington Avenue • Bellmore, NY 11710 • Tel: (516) 785-5709 • Fax: (516) 785-4468

Child's Name _____ Date _____
Address _____ Phone _____
_____ Date of Birth _____

IMMUNIZATION RECORD

IMMUNIZATION	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP (Diptheria, Tetanus, Pertussis)					
Polio					
Hib (Haemophilus Influenzae type b)					
Hep B (Hepatitis B – 3 doses)					
MMR (Measles, Mumps and Rubella)					
Varicella (Chicken Pox)					
Meningococcal					
Td					
Tdap					
Hep A					
Lead Screening	1 year	2 year			
TB test					
HPV					
Other					

Waiver of Vaccination (Please attach statement) Physician's Signature:

Vaccine Type_____ _____

Medical Exemption_____ Religious Exemption_____

NYSED requires an annual physical for new entrants, students in grades K, 2nd, 4th and 7th

HEALTH CERTIFICATE/APPRAISAL FORM
PLEASE COMPLETE

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

PLEASE ATTACH IMMUNIZATION RECORDS

PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal: _____ ☐ Medication: _____ ☐ Asthma: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Weight Status Category **BMI PERCENTILE REQUIRED**
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher
BMI INDEX REQUIRED _____ _____. _____

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL**

SCOLIOSIS: ☐ Negative ☐ Positive: _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

I assess this student to be self-directed ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting.

PHYSICAL EDUCATION / PLAYGROUND

____ **Cleared for physical education and playground.**
____ **Physical education and playground restrictions. Please specify** _____

____ **Known or suspected disability** _____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hypertension
☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

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DENTAL REPORT

Name_____ Date of Birth_____

- Has had all necessary work completed
- Is under treatment at present

Dentist's Signature:_____ Date:_____