

TO HELP US MAINTAIN OUR RECORDS CORRECTLY, PLEASE
PROVIDE US WITH THE FOLLOWING INFORMATION:

YORKTOWN CENTRAL SCHOOLS

Yorktown Heights, New York

Your child's Physician: _____

Phone: _____

Your child's Dentist: _____

Phone: _____

Date of latest dental exam: _____

Day of last eye exam _____

Examiner's Name: _____

Wears glasses: Yes ___ No ___ Contact Lenses: Yes ___ No ___

ILLNESSES, INJURIES OR OPERATIONS DURING THE PAST YEAR?

Any other pertinent information you might wish to add:

It is the policy of the District to ask parents to keep children home from school for several days if they show signs of a cold or other infection.

If you child has had a fever, he/she should not return to school until his/her temperature has been normal for at least 24 hours.

Dear Parent:

The New York State Education Law requires an annual examination for pupils on entrance to the school district and routinely at grades 2, 4, 7 and 10.

If your child has a yearly examination by your family physician, please ask the physician to complete this form.

The physical examination should be completed by October 1st. We would appreciate having the form returned to your child's school nurse by this date. After October 1st, the school physician must examine all pupils in the grades mentioned above, and all new entrants for whom we have no record of the family physician's report.

Yorktown Central School District

CHILD'S NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN: _____

MEDICAL HISTORY

DP/T Series	TOPV Series	Hepatitis B Vaccine
1) _____	1) _____	1) _____
2) _____	2) _____	2) _____
3) _____	3) _____	3) _____
4) _____	4) _____	
5) _____	5) _____	
MMR	1) _____ 2) _____	HIB Series
Or		1) _____
Measles	1) _____ 2) _____	2) _____
Mumps	1) _____ 2) _____	3) _____
Rubella	1) _____ 2) _____	4) _____
Meningococcal _____	Varivax _____	Other _____

MD verification of Chickenpox disease & Date: _____

TESTS AND RESULTS (WITH DATES)

HCT or Hb _____

Tuberculin _____

Urinalysis

 Glucose _____

 Protein _____

Vision: R _____ L _____

Hearing: R _____ L _____

SERIOUS ILLNESSES, ALLERGIES, INJURIES, OPERATIONS OR SIGNIFICANT HISTORY: _____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

CHILD'S NAME: _____ GRADE: _____

ADDRESS: _____

PHONE: _____

PHYSICAL EXAMINATION

- | | |
|-------------------------|-------------------------------------|
| 1. Height _____ | 16. Genitalia _____ |
| 2. Weight _____ | 17. Pulses _____ |
| 3. Blood Pressure _____ | 18. Tanner Scale _____ |
| 4. Eyes _____ | 19. Skin _____ |
| 5. Ears _____ | 20. Convulsive Disorder _____ |
| 6. Lymph-Nodes _____ | 21. Nervous System _____ |
| 7. Thyroid _____ | 22. Speech _____ |
| 8. Nose _____ | 23. Nutrition _____ |
| 9. Tonsils _____ | 24. Asthma _____ |
| 10. Heart _____ | 25. Food Allergy _____ |
| 11. Lungs _____ | 26. Medicine Allergy _____ |
| 12. Hernia _____ | 27. Bee Sting Allergy? |
| 13. Orthopedic | Yes _____ No _____ |
| a) Structural _____ | 28. Is child on daily medication? |
| b) Posture _____ | Name of Medication: |
| c) Scoliosis _____ | _____ |
| 14. Abdomen _____ | 29. Is child able to participate in |
| 15. Breast _____ | Physical Education activities? |
| | Yes _____ No _____ |

DATE OF EXAMINATION: _____

Physician's Name (Please Print)

Physician's Signature

Phone #: _____

CODE:

- N Normal or Negative
- X Observation
- XX Defect (Medical Care Needed)
- XXX Severe Defect (Immediate Care Needed)