

Northaven Co-operative Preschool Health Form

To be completed by parents:

Child's Name: _____ Class: _____

Parent's Name _____ Complete Address _____ Phone Number _____

Childs' Physician _____ Complete Address _____ Phone Number _____

I authorize my child's physician to share healthcare information with Northaven Co-Operative Preschool. In case of emergency, I authorize Northaven Co-operative Preschool to secure emergency services and to transport my child for emergency medical treatment, and I will pay the fees.

Parent Signature: _____ Date: _____

Allergies, special needs, chronic conditions: _____

Child's DOB: _____ Age at time of examination: _____

Results of Vision Screening: _____

Results of Hearing Screening: _____

If results of screenings are abnormal, what follow-up is recommended? _____

The health and developmental status of this child are satisfactory for participation in a school program. Developmental screening Instrument used: _____

No need for further developmental screening appears indicated at this time.

(This statement MUST be signed or stamped by physician.)

Signature of Physician: _____ Date: _____

(REQUIRED)

IMMUNIZATION RECORD

Each date must be filled in, or a complete immunization record attached. Boosters must be given when child turns 5 unless boosters were given after age 4. If child turns 5 during the school year, immunizations must be made current.

Vaccine	Date Given 1	Date Given 2	Date Given 3	Date Given 4	Date Given 5	Validation (Dr. or Clinic)
DTP/DTaP (after age 5, one booster since 4 th BD)						
Polio (after age 5, one booster since 4 th BD)						
MMR (1 dose after 1 st BD, after age 5, measles or MMR)						
Hib						
Hepatitis B (three doses by age 5)						
Varicella (1 dose or previous vericella illness)						
Hepatitis A						
Pneumococcal						