

Church Street Pre-School
P.O. Box 435, Valatie, NY 12184
(518) 758-6925

Health Form

Child's Name _____

Date of Birth _____ Examination Date: _____

To be completed by Physician:

Height _____ Weight _____

Posture _____ Tonsils _____

Eyes _____ Ears _____

Allergies _____ Food Allergies _____

Physical defects or Special Conditions _____

Physical Condition: _____ Excellent _____ Good _____ Fair

Dates student has been immunized against each of the following:

DPT _____ Hib _____

Polio Vaccine (IPV-3 or more) _____

Hepatitis B _____ MMR _____

Lead _____ Varicella _____

NOTE: These immunizations are required by New York State laws for all new entrants.

_____ has been examined by me and is capable of
(child's name) active participation in group activities.

_____ Date: _____
(Signature of Examining Physician)

**TO PARENTS: THIS FORM MUST BE PRESENTED ON
OR BEFORE THE FIRST DAY OF SCHOOL.**