Launchpad for Learning

9400 Transit Road - East Amherst, New York 14051 - 688-1772

Health & Immunization Record

This form is to be completed and signed by your child's doctor, or you may ask them for a standard preschool physical form with attached immunization record. All forms need to be returned to the preschool office before your child may start school.

Child's name _____ Male / Female

Address _____

Birth date _____/_____/_____

Physician's name _____ Phone # _____

Date of last examination _____ Height _____ Weight _____ BMI _____

Is there any condition requiring special attention by the school? Yes No
If Yes, please be specific _____

Do you consider the child physically capable of participating fully in all preschool activities? Yes No
If No, please detail all restrictions completely _____
_____

Does the child have any of the following?

Food allergies: Yes No
If Yes, please specify the allergy clearly_____
_____

Other allergies: Yes No
If Yes, please specify _____
_____

Sight impairment: Yes No
If Yes, please specify_____
_____

Hearing impairment: Yes No
If Yes, please specify_____
_____

Asthma: Yes No
If Yes, please specify _____
_____

Medications taken regularly: Yes No
If Yes, please specify dose and frequency_____
_____

Chronic diseases: Yes No
If Yes, please specify_____
_____

Physician's Signature _____ **Date** _____

New York State Public Health Law , section 2164 mandates that all schools shall not permit a child to be admitted unless the parent or guardian provides the school with an up to date certificate of immunizations.

Your physician may attach their record of immunization or fill in the form below.

Child's name _____ Birth date _____/_____/_____

DTP, DT, Or TD (3+) _____ _____ _____ _____ _____

Polio (3+) _____ _____ _____ _____ _____

Measles (1) _____ Mumps (1) _____ Rubella (1) _____

HIB (1+) _____

HEP B (3) _____

Tetanus (3) _____

Pertussis (3) _____

Varicella (1) _____

Pneumococcal (1+) _____

Lead Screening _____ Other (specify) _____

Any medical exemptions? Yes No

If Yes, please explain in detail_____

Physician's Signature _____ **Date** _____

Physician's Name Printed or stamp _____