WALLACE MEMORIAL NURSERY SCHOOL

Student Health Information

Student's Name_____Date of Birth_____

Parent's Name_____Phone_____

Address_____City _____Zip Code_____

Physician Information

All students attending Wallace Nursery School must have been examined by a pediatrician within 12 months of entering school**. I can accept a copy of the immunization record from the doctor's office. Please provide a copy.**

Pediatrician_____Phone Number_____

Last Physical Examination:_____
(date)

Results:

_____Within Normal Limit

_____Atypical Findings: (briefly explain)_____
_____
_____
_____
_____

Immunizations

Instead or taking this form to the doctor's office for completion and doctor's signature. We can accept an up to date copy of your child's immunizations. We will attach the copy to this form.

All children attending Wallace Nursery School must be immunized according to Pennsylvania State Regulations. Please indicate the correct number of doses for each vaccination received to date.

___doses of D.P.T. ___ doses Hib
___doses of Polio ___doses Pneumococcal conjugate
___dose M.M.R. ___doses of Hepatitis B

I have examined this student. He/She has been immunized according to state regulations **appropriate for his/her age** and is found to be in "normal" health.
Please indicate the correct number of doses per vaccine.

Physician's signature_____Date_____

GENERAL HEALTH INFORMATION

Students Name_____D.O.B._____

Does the student:

Have any special physical needs?

_____ no _____yes, please specify_____
_____

Have any chronic illness or special medical condition?

_____no _____yes, please specify_____
_____

Have any food allergy or food sensitivity?_____
_____

List food restrictions: _____
_____

Take medication daily? *please specify_____
_____

* Note: The Nursery School staff is not permitted to administer medication to students. Please be sure your child receives whatever medication is necessary before coming to school.

Parent's signature_____Date:_____