

Maplewood School & Summer Program
2166 Wantagh Avenue, Wantagh, NY 11793
(516) 221-2121 Fax (516) 221-9303
www.maplewoodschool.com

HEALTH FORM

Student's Full Name _____ Date of Birth _____
Home Street Address _____
City _____ State _____ Zip Code _____
Home Telephone Number _____
Father's Name _____ Father's Cell # _____
Father's Business Phone # _____ Father's Email _____
Address (if different from above) _____
Mother's Name _____ Mother's Cell # _____
Mother's Business Phone # _____ Mother's Email _____
Address (if different from above) _____

PHYSICIAN'S INFORMATION

Doctor's Name _____
Address _____
City _____ State _____ Zip Code _____
Office Telephone Number _____ Fax Number _____

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: ☐ May pick my child up from school ☐ May NOT pick my child from school
Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Emergency Contact #2: ☐ May pick my child up from school ☐ May NOT pick my child from school
Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____

SIGNATURE OF PARENT/GUARDIAN _____ Date _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child: _____

Date of Birth: _____

Date of Examination: _____

Immunizations required for entry into day care

☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ____ / ____ / ____ Mantoux Results: ☐ Positive ☐ Negative ____ mm
TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ____ / ____ / ____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ____ / ____ / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary
2 years ____ / ____ / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

____ / ____ / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.
If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)***Health Specifics****Comments**

Are there allergies? (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.

☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

()
Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

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Dear Parent/ Guardian:

Due to HIPAA regulations, your child's Physician, Nurse Practitioner, or Physician's Assistant is unable to release information about your child to anyone but yourself or anyone you designate to receive this information.

By signing the HIPAA RELEASE FORM below, you allow the Maplewood School to contact your child's health care provider should we have any questions concerning medications, or any questions, issues or concerns arise pertaining to your child's health.

Thank you.

HIPPA RELEASE FORM

**Dear Health Care
Provider:** _____

(Name of Physician)

I, _____

(Parent/Guardian)

**Parent/Guardian
of** _____

give permission for you to consult with and release information to:

**the MAPLEWOOD SCHOOL
2166 WANTAGH AVENUE, WANTAGH, NY 11793**

so that they can provide safe and appropriate care to my child concerning his/her medications and health care or if any questions, issues or concerns arise pertaining to my child's health.

**Signature of
Parent/Guardian:** _____

Date: _____