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**_____

I give consent for my child to be treated for routine health care.

SIGNATURE OF PARENT/GUARDIAN_____**Date**_____

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

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

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

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). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd 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)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ 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

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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: _____