Miss Barbara's Preschool
PO Box 484
10 Richmond Blvd.
Lake Grove, NY 11755
Tel: (631) 981-1271
Fax: (631) 981-4499

MEDICAL REPORT

Name_____ **Date of Exam** _____ **DOB** _____

Immunizations	Date	Date	Date	Date	Date
Diphtheria, Tetanus & Pertussis (DPT) Diphtheria & Tetanus &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 after 15 months	
Pnuemococcal Conjugate (PVC) -born after 1/1/08	1st date	2nd date	3rd date	4th date	
Hepatitis B	1st date	2nd date	3rd date		
Measles, Mumps & Rubella (MMR)	1st date	2nd date			
Varicella (also known as Chicken Pox)	1st date	2nd date			
Additional Immunizations					

Additional Information	**Comments**
Are there any allergies? ___ Yes ___ No	
Is medication taken regularly? 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	

Name_____

The above-named child is free from contagious and communicable disease and is able to participate in preschool.

Yes _____ No _____

_____	_____
Signature of Examiner	Address
_____	_____
Please Print Name	City, State, Zip
_____	(_____)_____ _____
Title	Phone Date

Please attach original immunization record to this form.