

Poly Prep Lower School
 50 Prospect Park West
 Brooklyn, NY 11215
 718-768-1103 Fax 718-768-1687

REQUIRED FOR NEWLY ADMITTED AND RETURNING STUDENTS
 Poly Prep Lower School requires each student to have a yearly physical exam. Please have form completed and signed by your physician and a parent and returned before the first day of school.

TO BE COMPLETED AND SIGNED BY PARENT

(Last) (First) (MI) DATE OF BIRTH SEX
 CHILD'S NAME _____ / ___ / _____ M ___ F ___ Class _____
 ADDRESS _____ Home Phone _____
 Parent #1 Name _____ Cell# _____ Bus.# _____
 Parent #2 Name _____ Cell# _____ Bus.# _____

Consent to Treat

I, the parent/guardian of this student, hereby give permission to Poly Prep CDS, if they are unable to contact me, to take any necessary steps to obtain proper treatment of my child in event of sudden illness or injury.

Parent/Guardian Signature: _____

MEDICAL EXAMINATION -TO BE COMPLETED AND SIGNED BY PHYSICIAN-

Immunization History

	1 st	2 nd	3 rd	4 th	5 th
DTP					
DT					
DTaP					
Hib					
OPV/IPV					
Hep B					
MMR					
Varicella					
Pneumococcal					
Influenza					
Hep A					
Rotavirus					
Other					

Students are required by NY State law to provide an up-to-date immunization history to attend school.

ALLERGIES: NO YES* Epi-pen Prescribed* YES

ASTHMA:

FOOD _____

CURRENT MEDICATIONS

MEDICINE _____

MDI _____

OTHER _____

OTHER _____

STUDENT NAME: _____

DOB: _____

Does student take any medication (prescribed &/or OTC)? Yes No If yes, please explain. _____

PERTINENT HEALTH HISTORY: Past/current illness, surgery, medication

PHYSICAL EXAMINATION

Height _____ in _____ (%) Weight _____ lbs _____ (%) BMI _____ (_____ %) B/P _____ / _____

General Appearance:

___NI ___Abnl HEET ___NI ___Abnl Lymph nodes ___NI ___Abnl Abdomen ___NI ___Abnl Genitourinary
___NL ___Abnl Neck ___NI ___Abnl Lungs ___NI ___Abnl Heart ___NI ___Abnl Back/spine
___NI ___Abnl Psychsocial ___NI ___Abnl Neurological ___NI ___Abnl Language ___NI ___Abnl Behavioral

Describe abnormalities:

SCREENING TEST	DATE DONE	RESULTS
Hematocrit		
Hemoglobin		
Lead Risk Assessment		
Lead Screening		
Tuberculin Screening (PPD Mantou		
Vision Screen: Right		
Left		
Auditory Screening: Right		
Left		
Urinalysis (optional)		

*See recommended schedule: Not required for all children.

DENTAL ASSESSMENT

Date: ___ / ___ / _____

Findings **1. No Visible Problems.....**
(Clean mouth, no visible cavities, healthy gums)
2. Some Problems Detected.....
(Cavities, inflamed gums, open bite, malocclusion)

Recommendations / Restrictions:

APPROVE PARTICIPATION IN PHYSICAL ACTIVITIES? YES NO

Health Care Provider (please print) _____

Signature of Provider _____ Date _____

License No. _____

Telephone No. _____

OFFICE STAMP
