

SAINT JOHN'S PRESCHOOL

St. John the Baptist RC Church
1488 North Country Road
Wading River, New York 11792

(631) 929-3220

Fax (631) 929-6961

HEALTH EXAMINATION & IMMUNIZATION RECORD

Student Name: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

Vision Acuity R _____ L _____ Eye Defects _____

Ears (otoscopic) _____

Lymph Nodes _____ Thyroid _____

Teeth: Temporary _____ Permanent _____

Nose _____ Tonsils _____

Heart _____ Lungs _____

Hernia _____ Genitor-Urinary _____

Structural Defect _____

Feet _____ Posture _____

Skin (non-commun) _____ Epilepsy _____

Nervous System _____ Speech _____

Nutrition _____ Other _____

Medication for any chronic condition _____

Restriction on play or other physical activities _____

Date of Examination _____ Physician's Signature _____

Please complete Immunization Record on reverse side.

Immunizations

DPT: 1.Date _____ 2. Date _____

3.Date _____ 4.Date _____

Polio: 1.Date _____ 2.Date _____ 3.Date _____

M/M/R: 1. Date _____

Hep. B: 1.Date _____ 2.Date _____ 3.Date _____

Varicella: 1.Date _____

HIB: 1.Date _____ 2.Date _____

3.Date _____ 4.Date _____

PCV: 1.Date _____ 2.Date _____

3.Date _____ 4.Date _____

Other: Date _____

Physician's Signature/Stamp

revised 06/14/23