



160 Main Street Southampton, NY 11968
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HEALTH / DR. RELEASE FORM

(Must be completed by Licensed Physician, Physician's Assistant or Nurse Practitioner)

Name of Child: _____ Gender: M F

Date of Birth: _____ Date of Examination: _____

Immunizations required:

Immunizations	1st Dose	2nd Dose	3rd Dose	4th Dose	Booster
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)					
Polio (IPV)					
Haemophilus influenza type B (Hib)					
Pneumococcal Conjugate (PVC)					
Hepatitis B					
Measles, Mumps, and Rubella (MMR)					
Varicella (also known as Chicken Pox)					

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

Immunization:	Date:	Immunization:	Date:
Immunization:	Date:	Immunization:	Date:
Immunization:	Date:	Immunization:	Date:

Tests: Tuberculin Test Date: _____

Mantoux Results: Positive Negative _____ mm

TB Tests are at the physician's discretion

If positive, or x-ray is ordered, attach a physician's statement documenting treatment and follow-up.

Lead Screening Date: _____ *Attach lead level statement.*

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HEALTH / DR. RELEASE FORM (continued)

Health Specifics: Are there any allergies? Yes (If yes, please specify) 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 Childcare 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 preschool.

Yes No

Signature of Examiner: _____ Date: _____

Print Name: _____ Phone #: _____

Address: _____

Title: _____