



# GARDEN SCHOOL

Jackson Heights, New York

Richard Marotta, Ph. D., Headmaster

## Garden School Health Record

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**Parent/Guardian 1** \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

**Parent/Guardian 2** \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

Pediatrician Name \_\_\_\_\_

Pediatrician Phone \_\_\_\_\_ Pediatrician Fax \_\_\_\_\_

### Student Health History (to be completed by physician)

#### Immunization Dates:

Hep B	_____	_____	_____	_____
Rotavirus	_____	_____	_____	_____
DTP/DTa/DT	_____	_____	_____	_____
Hib	_____	_____	_____	_____
PCV	_____	_____	_____	_____
Polio	_____	_____	_____	_____
Influenza	_____	_____	_____	_____
MMR	_____	_____	_____	_____
Varicella	_____	_____	_____	_____
Td	_____	_____	_____	_____
Tdap	_____	Hep A	_____	_____
Meningococcal	_____	_____	_____	_____
HPV	_____	_____	_____	_____
Mantoux TB Placed	_____	Mantoux TB read	_____	_____
Other	_____	_____	_____	_____



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## Garden School Health Record (cont.)

### Physical Exam

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Urinalysis \_\_\_\_\_ Pulse \_\_\_\_\_ Temperature \_\_\_\_\_

Blood Lead Level \_\_\_\_\_ Lead Risk Assessment \_\_\_\_\_

### Medical History

Asthma \_\_\_\_\_

ADHD \_\_\_\_\_

Allergies \_\_\_\_\_

Heart disorder (congenital) \_\_\_\_\_

Medications \_\_\_\_\_

Heart disorder (acquired) \_\_\_\_\_

Speech \_\_\_\_\_

Developmental/learning issues \_\_\_\_\_

Vision \_\_\_\_\_

Seizure disorder \_\_\_\_\_

Hearing \_\_\_\_\_

Tuberculosis (latent infection or disease) \_\_\_\_\_

Diabetes \_\_\_\_\_

Diabetes (new onset) \_\_\_\_\_

Please provide details and specify treatment plans (if any): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Illness, injury or surgery during the past year? \_\_\_\_\_

\_\_\_\_\_

Spinal screening for scoliosis? \_\_\_\_\_

\_\_\_\_\_

Full physical activity? \_\_\_\_\_ If no, please explain \_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Stamp here with name and license number

Date \_\_\_\_\_

Parent/guardian will be notified as quickly as possible in case of an emergency. Please sign below to grant Garden School and its agents permission to dispense over-the-counter medications as needed and to make decisions (including calling an ambulance) to secure medical treatment in an emergency.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_