

Setauket Presbyterian Preschool
P.O. Box 1006, Setauket, NY 11733

Health Record

To be completed by parent or guardian:

Child's Name _____ Date of Birth _____ Sex _____

Address: _____

Name of Child's Physician _____ Physician Phone _____

To be completed by Physician:

Medical History

Chicken Pox _____

Rheumatic Fever _____

Measles _____

Heart Disease _____

German Measles _____

Polio _____

Mumps _____

Pneumonia _____

Diphtheria _____

Tuberculosis _____

Whooping Cough _____

Allergies _____

Operations _____

Other _____

Immunization Dates

Triple Vaccine _____

Measles _____

Tuberculin Test _____

Mumps _____

Polio - Salk/Sabin _____

Rubella _____

Chicken Pox _____

HiB _____

Hepatitis B _____

Other _____

Has this child any physical, mental, or emotional handicaps which may affect his or her participation in a preschool program? If so, please explain.

Signature of Physician _____ Date _____