



BRIARCLIFF NURSERY SCHOOL

Medical Examination - Certificate of Immunization due THE FIRST DAY OF SCHOOL

**If physician uses his/her own form please make sure that
all the information on this sheet is included.**

Name _____ HT _____
Address _____ WT _____
_____ BP _____
Date of Birth _____

Physical Examination:

Serious Illness:
Allergies:
Medications:
Physical Restrictions:

**Mandated New York State Department of Health Immunizations: Please list dates that
dose was given:**

Polio (3 doses) _____
DPT (4 doses) _____
Measles (1dose) _____
Mumps (1 dose) _____
Rubella (1 dose) _____
Hib (3 doses or one dose after 15 mos of age) _____
Hep B (3 doses) _____
Varicella (1 dose) _____
Pneumococcal (4 doses) born after 1/1/08 _____

**For More information contact New York State Department of Health, Bureau of
Communicable Disease Control Immunization Program (518) 473-4437. Medical Exemptions
to Immunizations must be in writing from your doctor. Religious Exemptions to Immunizations
require a separate form, please request form from school Director. Exemptions must accompany
this medical form.**

Has child had chickenpox? _____ Date _____
Has child had lead screening test? _____ Date _____

Name of Physician _____ Date Last Seen _____
Address _____
Telephone _____
Signature of Physician _____

Return to:

**Briarcliff Nursery School
P.O. Box 28 Briarcliff Manor, NY 10510
(Phone: 914-693-9072)**

New York State law requires us to have the original form – no copies or faxes.