

Name of Child \_\_\_\_\_

(last, first name)

Date of Birth \_\_\_\_\_

Carousel Day School  
9 West Avenue  
Hicksville, N.Y. 11801



**ANNUAL PHYSICAL EXAMINATION**

- |                          |                          |                             |
|--------------------------|--------------------------|-----------------------------|
| 1. Height _____          | 7. Nose _____            | 15. Orthopedic _____        |
| 2. Weight _____          | 8. Throat _____          | a. Structural _____         |
| 3. Eyes & Eyelids _____  | 9. Lymph Nodes _____     | 16. b. Bones & Joints _____ |
| 4. Ears & Eardrums _____ | 10. Heart _____          | c. Feet _____               |
| R _____                  | 11. Lungs _____          | 17. Nervous System _____    |
| L _____                  |                          | 18. Nutrition _____         |
| 5. Skin & Hair _____     | 12. Abdomen _____        | 19. Tuberculin Test _____   |
| 6. Teeth & Gums _____    | 13. Hernia _____         | 20. Blood Pressure _____    |
|                          | 14. Genito-Urinary _____ | 21. Scoliosis _____         |

**IMMUNIZATION RECORD**

1st Immunization  
(month/day/year)

2nd Immunization  
(month/day/year)

MMR(after one year of age) \_\_\_\_\_

Measles (live vaccine after one year of age) 2nd Dose required before entering kindergarten \_\_\_\_\_

Mumps (after one year of age) \_\_\_\_\_

Rubella (after one year of age) \_\_\_\_\_

HIB (between 15 months and 5 years of age) \_\_\_\_\_

Hepatitis B (3 doses required for pre-k and nursery children born on or after 1/1/95) 3 doses for kindergarteners born on or after 1/1/93 \_\_\_\_\_

Lead Screening (recommended) \_\_\_\_\_

Polio: Sabin (TOPV at least 3 doses)

Dates	Dates of Boosters
#1 _____	#1 _____
#2 _____	#2 _____
#3 _____	#3 _____

Dates	Dates of Boosters
#1 _____	#1 _____
#2 _____	#2 _____
#3 _____	#3 _____

- Are there any allergic problems? \_\_\_\_\_
- Are there allergies to drugs? \_\_\_\_\_
- Is medication taken regularly? If yes, what kind? \_\_\_\_\_
- Are there any conditions requiring special attention by the school? \_\_\_\_\_

Date of Examination \_\_\_\_\_ Physician Signature \_\_\_\_\_ Physician Stamp \_\_\_\_\_

The Nassau County Board of Health regulations require that each child must have an annual physical examination.