

YORKTOWN COMMUNITY NURSERY SCHOOL  
P.O. BOX 1146  
Yorktown Heights, NY 10598  
(914) 962-7868  
Fax (914) 962-1349

## HEALTH FORM

Child's Name \_\_\_\_\_ Age \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

IMMUNIZATIONS	DATES
DPT	
Polio	
Measles	
Mumps	
Rubella	
Haemophilus type B	
Hepatitis B	
Varicella	

**Allergies** \_\_\_\_\_

**Childhood Diseases** \_\_\_\_\_

**Lead blood test results** \_\_\_\_\_

Please have your Doctor complete the above and then fill in and sign the following:

I examined \_\_\_\_\_ on \_\_\_\_\_

(child's name)

(exam date)

and found this child to be in good health and able to participate in the nursery school program.

\_\_\_\_\_ M.D.