THE MARION & AARON GURAL JCC Early Childhood Center

140 CENTRAL AVENUE • LAWRENCE, NY 11559
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JCC.NURSERY@GURALJCC.ORG

ROOM #

NOTE: YOU MAY ATTACH A PRINT OUT FROM YOUR DOCTOR TO THIS FORM BUT THIS FORM MUST BE SIGNED AT THE BOTTOM BY YOUR DOCTOR.

MEDICAL HEALTH REPORT

SUMMER 25/SCHOOL 2025-26

CHILD'S NAME _____ **DOB** _____ **DATE OF EXAM:** _____

PHYSICAL EXAM

HEIGHT: _____ WEIGHT: _____

IMMUNIZATIONS & DATES

MMR 1. _____ 2. _____

PNEUMOCOCCAL (PCV) 1. _____ 2. _____ 3. _____ 4. _____

DTaP 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

IPV 1 _____ 2. _____ 3. _____ 4. _____

HIB 1. _____ 2. _____ 3. _____ 4. _____

HEP B 1. _____ 2. _____ 3. _____ 4. _____

HEP A 1. _____ 2. _____

VARICELLA 1. _____ 2. _____ **LEAD SCREENING** _____

OTHER TYPE _____ DATE(S) 1. _____ (attach statement of lead screening)

TYPE _____ DATE(S) 1. _____

TESTS

TUBERCULIN – MANTOUX DATE _____ RESULTS: ☐ POS ☐ NEG

If positive, attach physician's statement documenting treatment and follow-up.

HEALTH SPECIFICS

☐ YES ☐ NO **Are there any allergies?** (Specify) _____

☐ YES ☐ NO **Is an EPI pen required?** _____

☐ YES ☐ NO Is medication taken regularly? _____

Specify drug and condition. _____

☐ YES ☐ NO Is a special diet required? _____

Specify diet and condition. _____

☐ YES ☐ NO Are there any hearing, visual or dental _____

conditions requiring special attention? _____

☐ YES ☐ NO Are there any medical or _____

developmental conditions requiring _____

special attention? _____

THE NASSAU COUNTY DEPARTMENT OF HEALTH AND NYS OFFICE OF CHILDREN AND FAMILY SERVICES REQUIRE THAT ALL CHILDREN HAVE AN UP-TO-DATE MEDICAL ON FILE. YOUR CHILD WILL NOT BE PERMITTED TO START SCHOOL OR CAMP AT THE JCC WITHOUT ALL UP-TO-DATE IMMUNIZATIONS. EXEMPTIONS WILL NOT BE ACCEPTED. THIS FORM MUST BE SIGNED AND DATED BY YOUR PHYSICIAN.

Summary of physical exam (including special recommendations to Day Care Provider)

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.

Yes☐ No☐

_____ _____ _____ _____

_____ _____ _____ _____

DOCTOR'S SIGNATURE **PHONE NUMBER** **ADDRESS** **TOWN/ZIP**