

**MEDICAL REPORT – ST. LUKE PRESCHOOL,  
20 CANDLEWOOD PATH, DIX HILLS, NY 11746 (631/462-5216)**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

In accordance with New York State Public Health Law 2164, a Certificate of Immunization, signed by a physician, listing exact dates, must be on file the **first day of school!!!** **A CHILD WILL NOT BE ABLE TO ATTEND SCHOOL WITHOUT THIS FORM ON FILE !**

**PHYSICIAN'S REPORT:** *(To be filled out by doctor)* Doctor's office may fill out this form or attach their copy of your child's immunization to this form and return to St. Luke Preschool  
**NLT: AUGUST 3, 2009.**

**CERTIFICATE OF IMMUNIZATION**

Minimum 3 or more full doses dates **(required for school attendance):**

Diphtheria	__/__/__	__/__/__	__/__/__	__/__/__
Polio (IVP or OPV)	__/__/__	__/__/__	__/__/__	__/__/__
Hepatitis B	__/__/__	__/__/__	__/__/__	__/__/__
<i>OR</i>				
Pediarix	__/__/__	__/__/__	__/__/__	__/__/__
Hib Vaccine	__/__/__	__/__/__	__/__/__	__/__/__

Minimum 1 full dose dates **(required for school attendance):**

Mumps	__/__/__	__/__/__
Measles	__/__/__	__/__/__
Rubella	__/__/__	__/__/__
<i>OR</i>		
MMR	__/__/__	__/__/__
Varicella (Chicken Pox)	__/__/__	__/__/__

PHYSICIAN'S SIGNATURE \_\_\_\_\_ Telephone # \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT'S REPORT:** *(To be filled out by parent)*

CHILD'S NAME: \_\_\_\_\_

Program:	Learn & Play:	AM/PM	2-DAY;	3-DAY;	4-DAY;	5-DAY
(Circle)	Preschool:	AM/PM	2-DAY;	3-DAY;	4-DAY;	5-DAY
	Pre-K:	AM/PM	2-DAY;	3-DAY;	4-DAY;	5-DAY

Does this child require special attention or medication that we should be aware of:

IF SO, SPECIFY: \_\_\_\_\_

List of all allergies: \_\_\_\_\_

Physical impairments: \_\_\_\_\_

Surgical procedures: \_\_\_\_\_

Hospitalization: \_\_\_\_\_

In case of emergency, when parent, guardian or family physician cannot be reached, we grant permission to St. Luke to provide for the necessary medical attention for our child.

\_\_\_\_\_  
Parent's or Guardian's Signature Telephone Number Date