YORKTOWN COMMUNITY NURSERY SCHOOL
P.O. Box 1146, 247 Veterans Road, Yorktown Heights, NY 10598
Phone: (914) 962-7868 Fax: (914) 962-1349
www.ycns.org

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 _____

Vision Test results _____

Hearing 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.