

Saint Edmund Preparatory High School  
www.stedmundprep.org



2474 Ocean Avenue • Brooklyn, NY 11229  
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Dear Parent/Guardian:

The New York Public Health Law & St. Edmund policy mandates that ALL new entrants must submit ALL of the following in order to attend school:

\_\_\_ a completed medical evaluation - must include height, weight, blood pressure, medical history, a developmental on the attached form assessment, anemia screening, vision, hearing, dental screening.

**THIS MUST HAVE BEEN DONE WITHIN 12 MONTHS OF ADMISSION (9-1-10)**

\_\_\_ a Mantoux (PPD) test for tuberculosis - also within 12 months of admission

\_\_\_ 4 doses of Diphtheria vaccine - DtaP or DTP or DT or Td

\_\_\_ 1 dose of Tdap vaccine – all 9<sup>th</sup> grade students

\_\_\_ 3 doses of Polio vaccine - OPV or IPV

\_\_\_ 2 doses of MMR vaccine - 1 dose given on or after the 1<sup>st</sup> birthday, and the 2<sup>nd</sup> at least 28 days after the 1<sup>st</sup> dose & at or after age 15 months

\_\_\_ 3 doses of Hepatitis B vaccine

\_\_\_ 1 dose of Varicella vaccine – given on or after the 1<sup>st</sup> birthday –although not required a 2<sup>nd</sup> dose is highly recommended

The form on the back of this letter must be signed & MECHANICALLY STAMPED by your physician & returned to me **before July 31, 2010** to guarantee no delay in your child starting school.

**\*\*Please note the permission slip at the bottom of Parent portion of the form. This must be signed if you wish me to give Tylenol or Advil to your child for headache or minor aches and pains.\*\***

If you have any questions, please feel free to call me at 743-6100, during regular school hours. I look forward to working with you in the years to come to ensure your child's health and safety.

Sincerely,

Kathryn DeMello R.N  
School Nurse

# St. Edmund Prep H.S.

## New Admission Examination Form

**TO BE COMPLETED BY THE PARENT OR GUARDIAN**

STUDENT LAST NAME			FIRST NAME			MIDDLE			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		BIRTHDAY MONTH DAY YEAR			RACE/ETHNICITY <i>Check all that Apply</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Other		
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<input type="checkbox"/> PARENT			LAST NAME			FIRST NAME			STUDENT ADDRESS			APT./FL.			TELEPHONE NO.		
<input type="checkbox"/> GUARDIAN												HOME: ( )					
<input type="checkbox"/> FOSTER PARENT												ZIP			WORK: ( )		

I give permission for my child to be given Tylenol or Advil in the event of minor headache, aches or pains  Yes  No  
 Parent Signature \_\_\_\_\_

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

Does the student have a past or present medical history of the following:

PRES. PAST NO	ASTHMA (If present, attach medication administration form)	PRES. PAST NO	Diabetes (If present, attach medication administration form)	PRES. PAST NO	Speech Problems	DATE	DETAILS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**PHYSICAL EXAMINATION:** HEIGHT \_\_\_\_\_ in ( %ile ) WEIGHT \_\_\_\_\_ lb ( %ile ) BMI ( %ile ) BLOOD PRESSURE \_\_\_\_\_ / \_\_\_\_\_

GENERAL APPEARANCE (NUTRITIONAL STATUS):

<input type="checkbox"/> HEENT	<input type="checkbox"/> LYMPH NODES	<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> BACK	<input type="checkbox"/> GROSS MOTOR
<input type="checkbox"/> DENTAL STATUS	<input type="checkbox"/> LUNGS	<input type="checkbox"/> GENITO URINARY	<input type="checkbox"/> SKIN	<input type="checkbox"/> PSYCHOSOCIAL DEV.
<input type="checkbox"/> NECK	<input type="checkbox"/> CARDIOVASCULAR	<input type="checkbox"/> EXTREMITIES	<input type="checkbox"/> NEURO	<input type="checkbox"/> LANGUAGE
DESCRIBE ABNORMALITIES:				<input type="checkbox"/> BEHAVIORAL
				<input type="checkbox"/> FINE MOTOR

<b>SCREENING TESTS:</b>	DATE	RESULTS	<b>Hearing</b>	DATE	RESULTS	<b>Vision</b>	<i>Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test.</i>
HEMATOCRIT/HEMOGLOBIN	___/___	<input type="checkbox"/>	AUDIO/SWEEP	___/___	P F	DATE	
HGB ELECTROPHORESIS	___/___		THRESHOLD	___/___	P F		
OTHER TESTS	___/___						

<b>TB</b>	MANTOUX	DATE	RESULTS	Chest X-ray	BCG	On INH	FAR	NEAR
	(PPD) IMPLANTED	___/___	<input type="checkbox"/> NEGATIVE	DATE	___/___	<input type="checkbox"/> YES	Right	Left
	READ	___/___	<input type="checkbox"/> POSITIVE	RESULTS	<input type="checkbox"/> Normal	<input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/> Abnormal	<input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/> Not Indicated	<input type="checkbox"/> NO	Both	
							<input type="checkbox"/>	<input type="checkbox"/>
							FUSION	P F
							COLOR	P F

Child can receive Tylenol/Advil in the event of minor headaches, aches and pains.  Yes  No

**IMMUNIZATION — DATES** Citywide Immunization Registry no. \_\_\_\_\_

DPT/DTaP or DT or Td	___/___	___/___	___/___	___/___	___/___	Measles	___/___
IPV/OPV	___/___	___/___	___/___	___/___	___/___	Mumps	___/___
Hepatitis B	___/___	___/___	___/___	MMR	___/___	Rubella	___/___
HB	___/___	___/___	___/___	VZV	___/___	Other	___/___

<b>DIAGNOSES — If Asthma, indicate severity</b>	DATE OF EXAM:	<b>PHYSICIAN'S STAMP REQUIRED BELOW</b>
<input type="checkbox"/> Well Child V202	MONTH DAY YEAR	
ICD CODE	Physician Signature	
1. _____	Physician Name (Print)	

**RECOMMENDATIONS/REFERRALS**

FULL PHYSICAL ACTIVITY INCLUDING PHYSICAL EDUCATION, AEROBICS, AND SPORTS.

STUDENT IS ALSO APPROVED FOR WORKING PAPERS.

RESTRICTIONS Specify limitations and/or special alerts (i.e. allergies, medications, precautions)