

Saint Edmund Preparatory High School  
www.stedmundprep.org



2474 Ocean Avenue • Brooklyn, NY 11229  
P: 718.743.6100 • F: 718.743.5243

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 (9-1-09)**

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

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

\_\_\_\_\_ 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, 2009** 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 Check all that Apply <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 <input type="checkbox"/> GUARDIAN <input type="checkbox"/> FOSTER PARENT			LAST NAME			FIRST NAME			STUDENT ADDRESS			APT./FL.			TELEPHONE NO. HOME: ( ) WORK: ( )		
									ZIP								

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

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

<input type="checkbox"/> TB MANTOUX DATE _____ RESULTS _____ (PPD) IMPLANTED _____ <input type="checkbox"/> NEGATIVE _____ MM READ _____ <input type="checkbox"/> POSITIVE _____ MM	Chest X-ray DATE _____ RESULTS <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Indicated	BCG DATE _____ RESULTS <input type="checkbox"/> YES <input type="checkbox"/> NO	On INH DATE _____ RESULTS <input type="checkbox"/> YES <input type="checkbox"/> NO	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	___/___	___/___	___/___	___/___	___/___	Rubella	___/___	___/___
HB	___/___	___/___	___/___	___/___	___/___	Other	___/___	___/___

DIAGNOSES — If Asthma, indicate severity <input type="checkbox"/> Well Child V202 ICD CODE _____ 1. _____ 2. _____ 3. _____		DATE OF EXAM: _____ MONTH DAY YEAR Physician Signature _____ Physician Name (Print) _____	<b>PHYSICIAN'S STAMP REQUIRED BELOW</b>
RECOMMENDATIONS/REFERRALS <input type="checkbox"/> FULL PHYSICAL ACTIVITY INCLUDING PHYSICAL EDUCATION, AEROBICS, AND SPORTS. STUDENT IS ALSO APPROVED FOR WORKING PAPERS. <input type="checkbox"/> RESTRICTIONS Specify limitations and/or special alerts (i.e. allergies, medications, precautions)		Address _____ Telephone _____	