

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 (9-1-11)

_____ 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 9th & 10th grade students

_____ 3 doses of Polio vaccine - OPV or IPV

_____ 2 doses of MMR vaccine - 1 dose given on or after the 1st birthday, and the 2nd at least 28 days after the 1st dose & at or after age 15 months

_____ 3 doses of Hepatitis B vaccine

_____ 1 dose of Varicella vaccine – given on or after the 1st birthday –although not required a 2nd 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, 2011** 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			STUDENT ID # / OSIS			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			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"/>		
<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
				<input type="checkbox"/> BEHAVIORAL
				<input type="checkbox"/> FINE MOTOR

DESCRIBE ABNORMALITIES: _____

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	
HGB ELECTROPHORESIS	___/___		THRESHOLD	___/___	P F		
OTHER TESTS	___/___						

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

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	___/___

DIAGNOSES — If Asthma, indicate severity

<input type="checkbox"/> Well Child V202	ICD CODE	DATE OF EXAM:	MONTH	DAY	YEAR
1. _____	____	Physician Signature	_____		
2. _____	____	Physician Name (Print)	_____		
3. _____	____	Address	_____		

**PHYSICIAN'S STAMP
REQUIRED BELOW**

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)