REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER

Name:

Sex:

School:

Grade:

Allergies

Additional Information Attached

Name: DOB:

SCREEN

Referral

Yes No

IMMUNIZAT

Record Attached

Received Today: Yes

Date:

Stamp:

Signature:

Provider Name: *(please print)*

Phone:

Fax: