MEDICAL FORM
PHONE: (845) 364-2032
FAX: (845) 364-2093

Please return this form to: Provider Name: _____
Address: _____
Phone_____ Fax_____

Child's Name _____DOB: _____

Parent's Name _____

Address _____

Immunization History	Birth – 2 Months	4 Months	6 Months	12-18 Months	18-24 Months	24-30 Months	30-36 Months
Hepatitis B							
Rotavirus							
Diphtheria, Tetanus, Pertussis							
Pneumococcal							
Inactivated Poliovirus							
Influenza							
Measles, Mumps, Rubella							
Varicella							
Hepatitis A							
Meningococcal							

Testing: Lead:_____ Results:_____ TST:_____ Results:_____ Hgb:_____ Results:_____
Date of Last Exam:_____ Ht.:_____ Inches_____% Wt.:_____lbs._____% FOC_____%
Ophthalmology: _____ Results: _____
Audiology: _____ Results: _____
Referrals made to other Physician's/Specialists:_____

History:
Please describe below or attach a description of child's medical history that has an identified or potential impact upon his developmental growth: birth defects, prematurity, addiction, respiratory/cardiac compromise, seizure activity, feeding difficulties, other pre-natal or neo-natal difficulties or history of accidents, injuries, hospitalizations, etc.:_____

Developmental Screens:_____

Please describe child's current medications, medical needs or concerns, if any:

_____

Please describe any emotional, social or behavioral problems of which you are aware:

_____

I hereby recommend that this child receive services from Early Intervention that may include occupational therapy, physical therapy, speech, social work, special education, and/or assistive technology services; if found eligible as per Early Intervention New York State Regulations and as per the IFSP.

Physician's Name (please print):_____

MD Signature:_____ Date: _____