



# ALL ABOUT KIDS™

Evaluations & Therapy Services

## CONSENT TO OBTAIN PHYSICAL EXAM & RECORD OF IMMUNIZATION

I am aware that through the Early Intervention Program evaluation process, I am entitled to a physical examination for my child at no cost. However, I have chosen to use my child's pediatrician. I hereby authorize:

\_\_\_\_\_  
(Pediatrician's Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State & Zip)

\_\_\_\_\_  
(Phone Number or Fax Number)

to forward a copy of \_\_\_\_\_ DOB \_\_\_\_\_  
(Child's Name)

most recent physical exam and an up-to-date record of immunization to ALL ABOUT KIDS. Thank you for your assistance in this matter.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

Please fax to 914-251-1266

*All About Kids follows FERPA regulations providing for confidentiality of information that is exchanged.*

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## Early Intervention Program Medical Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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
(DtaP) Diphtheria, Tetanus, Pertussis							
(IPV) Polio (Hib) Haemophilus Influenzae type b							
(Hep B) Hepatitis B							
(MMR) Measles, Mumps, Rubella							
PCV Pneumococcal Conjugate							
Chickenpox (Varicella)							

Testing: Lead: \_\_\_\_\_ Results: \_\_\_\_\_ TB: \_\_\_\_\_ Results: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ (Ht.) \_\_\_\_\_ inches \_\_\_\_\_ % (Wt.) \_\_\_\_\_ lbs. \_\_\_\_\_ %

Ophthalmology: \_\_\_\_\_ Results: \_\_\_\_\_

Audiology: \_\_\_\_\_ Results: \_\_\_\_\_

Referrals to other physicians: \_\_\_\_\_

Please describe below or attach 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, hospitalization, etc.

Please describe child's current medications, medical needs or concerns including allergies, 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, and/or assistive technology services; if found eligible as per EI NY State Regs. and as per the IFSP.

Physician's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_