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.

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) Haemophilius 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: ______________

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