ALL ABOUT KIDS™

Evaluations & Therapy Services For All Children

www.allaboutkidsny.com

ANNUAL PHYSICAL FORM

Last Name:	First Name:	Middle:	D/O/B:	Date of Exam:
Street Address:		City:	State:	Zip Code:
Home Phone:	Cell Phone:	Job Title:	E-Mail:	

Note: In accordance with DOH Guidelines for Health and Safety Standards, all providers delivering services must provide an annual statement demonstrating evidence that he/she has no diagnosed disorder that would preclude him/her from providing services, and is free from communicable diseases.

PHYSICAL FINDINGS: To be Completed By The Doctor. All "lab Work" Must Be Attached.			
Height:	Weight:	Blood Pressure:	Pulse:

PAST MEDICAL HISTORY (please check Yes or No)

Condition	**Yes**	**No**	**Please Explain any positive findings, list and explain any chronic medications or therapies:**
Hypertension			
Heart Disease			
Diabetes			
Seizure Disorder			
Chronic Lung Disease			
Mental Illness			
Alcohol Abuse			
Substance Abuse			
Physical Disabilities			
Hepatitis			
Other (Specify)			

TUBERCULIN TESTING: **Annual Tuberculin Skin Test: PPD MANTOUX**	**Date Tested:** **Date Interpreted:** **Results:**

A Mantoux test is required every year unless previously positive.
A chest x-ray is required only when the Mantoux is positive and only until a negative x-ray is on record at least 18 months after the positive Mantoux was noted or after completion of treatment.

Chest X-Ray:

Date: **Results:**

Executive Office Nassau
255 Executive Drive, Suite LL 105/108
Plainview, NY 11803
516-576-2040
Fax: 516-576-2131

Suffolk
150 Vanderbilt Motor Pkwy. Suite 401
Hauppauge, NY 11788
631-439-6860
Fax: 631-439-6861

Queens/Manhattan
37-11 35th Avenue Suite 3C
Astoria, NY 11101
718-706-7500
Fax: 718-706-9595

Brooklyn
175 Remsen Street Suite 750
Brooklyn, NY 11201
718-522-7300
Fax: 718-522-5280

Bronx
3140B E. Tremont Avenue
Bronx, NY 10461
718-239-4147
Fax: 718-239-4310

Westchester
145 Huguenot Street Suite 404
New Rochelle, NY 10801
914-251-0905
Fax: 914-251-1266

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IMMUNIZATION RECORD:	
	Vaccinated:
Hepatitis B: (either provide proof of immunization series, a positive test titre, or a signed document of refusal of vaccine)	
Diphtheria:	
Tetanus:	
Pertussis:	
Varicella:	
Influenza:	
Measels/Mumps/Rubella:	

VACCINATION REFUSAL- To BE Completed By Patient If ANY of The Above Recommended Vaccinations Have Been Refused.

I understand:

- The purpose of and the need for the recommended vaccine(s).
- The risks and benefits of the recommended vaccine(s).

I know that my failure to follow these recommendations for vaccination may endanger my health or the health of people I come in contact with.

I know that, even though I refuse to be vaccinated now, I can change my mind at any time and accept vaccination in the future. I acknowledge that I have read this refusal form in its' entirety and fully understand it.

Patient Signature:	**Date:**

Based on health history provided, physical examination and/or laboratory tests performed, this patient is permitted to work in the health care field without restriction.

______________________________________ ______________________________________

Physician's Signature License Number

___________________________ ______________________________________

Telephone Number Address

___________________________ ______________________________________

Date of Exam Stamp or Print Information

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