

IMMUNIZATION RECORD/PHYSICAL EXAMINATION FORM FOR GRADES Pre K4 - 5

Name of Student _____ Date of Birth _____ Grade _____

Address _____ City _____ State _____ Zip _____ Phone # _____

IMMUNIZATION DATES

<u>D.P.T.</u>		<u>POLIO VACCINE</u> (Indicate OPV or IPV)	<u>MMR</u>
1 st _____	4 th _____	1 st _____	1 st _____
2 nd _____	5 th _____	2 nd _____	2 nd _____
3 rd _____	Td _____	3 rd _____	VARICELLA _____
	Tdap _____	4 th _____	MENINGOCOCCAL _____
<u>HEP.B</u>	<u>HIB</u>	<u>MANTOUX</u>	PNEUMOCOCCAL _____
_____	_____	Date _____	INFLUENZA _____
_____	_____	Results _____	
_____	_____	<u>OTHER VACCINES</u> _____	

Height _____ Weight _____ BP _____

Significant illnesses, accidents, congenital defects, allergies, etc.: _____

Significant factors in family situation or family history: _____

Please examine the following and indicate findings as normal or abnormal:

	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>
Skin	_____	_____	Hernia	_____	_____
Eyes	_____	_____	Posture	_____	_____
Ears	_____	_____	Scoliosis	_____	_____
Nose/Throat/Mouth	_____	_____	Extremities	_____	_____
Glands	_____	_____	Genito-urinary	_____	_____
Heart	_____	_____	Nutritional Status	_____	_____
Lungs	_____	_____	Neurological	_____	_____
Abdomen	_____	_____	Balance & Coordination	_____	_____

If Abnormal, Treatment Advised: _____

Current Medications: _____

Please specify medical recommendations to school for academic and activity program.

Date: _____ Signature of Examiner: _____ Phone: _____

Address: _____

NOTE: ANY MEDICATIONS – OTC or RX – TO BE GIVEN IN SCHOOL MUST HAVE WRITTEN M.D. NOTE AND PARENT NOTE REWRITTEN FOR EACH SCHOOL YEAR