PHYSICIAN'S EXAMINATION & IMMUNIZATION RECORD

Student Name _____ Date of Birth _____

Note: This is to be completed by your physician and MUST include immunizations. Please take student's early morning urine specimen to the doctor's office on the day of the examination.

1. Does this student have any physical health problems?_____
   ❑Cardiac ❑Asthma ❑Allergies ❑Convulsive Disorders ❑Blood Dyscrasia ❑Diabetes ❑Neurologic
   ❑Other: explain _____
2. Does this student have any problems which might influence his/her school adjustment? _____
   _____
3. Is there any physical defect or illness which should restrict the student's activities at school in any way?
   _____
4. List any medication the student should take while at school: _____
   _____
5. This student should continue under medical care for the conditions specified: _____
   _____

		Under Care		Normal		Referred	
	Measurement	Yes	No	Yes	No	Yes	No
Height							
Weight							
Blood Pressure							
Vision Deficiency							
Hearing Deficiency							
Speech Problem							

Additional Comments: _____

PPD TB Test Date_____/_____/_____ Result _____ Type follow-up if positive _____
Date and Place if chest x-ray _____

This is to certify that _____ (student) is free from communicable disease and is not a health threat to either patients or other staff. Furthermore, the above named person appears to be in good health.

Date: _____ Physician's Signature _____

IMMUNIZATION RECORD

Immunizations	Dates (month/day/year)	Minimum Required
DTP or Td (Diptheria, Tetnus Pertussis)	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Infant series of 5 boosters before 4th birthday.
	_____/_____/_____ _____/_____/_____	Td booster every 10 years thereafter.
Oral Polio Vaccine	_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____	Infant series of 4 boosters
MMR (Measels, Mumps, Rubela)	_____/_____/_____ _____/_____/_____	2 doses before 7th grade

For immunizations still needed, please take this form with you to the doctor or health dept. If it is necessary to have immunizations at Laurelbrook Academy, please sign the following: I give permission for the student named above to have needed immunizations at LBA through the Rhea County Health Department.

_____
Parent/Guardian Signature