



IMMUNIZATION AND MEDICAL HISTORY

Last Name	First Name	Social Security #	Date Of Birth			ID
			Month	Day	Year	

Return this form by August 31, 2011

DPT or DT or TD _____
Date Date Date Date Date

POLIO _____
Date Date Date Date Date

MMR _____
Date Date

HEPATITIS B _____
Date Date Date Date

HIB _____ (Pre-K attendees only)
Date Date Date Date

VARICELLA _____ LAST TETANUS VACCINE _____
Date 1 Date 2 Date

OTHERS _____
(Type & Date) (Type & Date) (Type & Date)

Height _____ Weight _____ Blood Pressure _____

Vision Right _____ Vision Left _____ Hearing _____

Lead _____ Urinalysis _____ Hemoglobin _____ Strabismus _____

CHRONIC HEALTH Asthma _____ Seizure Disorder _____ ADD/ADHD _____ Diabetes _____

CHRONIC MEDICATIONS Medications _____ Dose _____ Frequency _____

Signature of Preparer _____ Date ** _____

* WHEN APPROPRIATE MEDICAL DOCUMENTATION INDICATES THAT THE STUDENT HAD THE DISEASE, ATTACH COPY OF DOCUMENTATION.

** ALL INFORMATION ENTERED SUBSEQUENT TO THIS DATE MUST BE INITIALED.

MEDICAL HISTORY

Date of Last Physical Exam _____
Date

Any Special Need Requirements For Student _____

Chronic Health Problems or restrictive conditions _____
