



Early Childhood Center

Medical Form

Student: _____ Birth Date: _____

This student was found to be in good health and able to participate in school activities. yes no
Restrictions: _____

Immunization Record:

DATE OF LAST PHYSICAL _____

DT/DTP: 1. _____
2. _____
3. _____
4. _____
5. _____

Allergies: _____
Treatment _____
Asthma: _____
Treatment: _____

IPV/OPV: 1. _____
2. _____
3. _____
4. _____

Chicken pox? _____ date _____
Hgb/Hct: _____
Urinalysis: _____
TB Testing:/ low risk: _____

MMR: 1. _____
2. _____

Scoliosis yes _____ no: _____
Ht: _____ Wt: _____ Bp: _____
Vision: _____
Abnormal findings: _____

HEP B: 1. _____
2. _____
3. _____

Additional Pertinent Information / Meds:

HIB: 1. _____
2. _____
3. _____
4. _____

HEP A 1. _____ 2. _____

VARIVAX: 1. _____ 2. _____

PCV 1. _____ 2. _____ 3. _____ 4. _____

Influenza 1. _____ 2. _____ 3. _____ 4. _____

Rotavirus 1. _____ 2. _____ 3. _____

LEAD: date: _____ level: _____ **MD'S SIGNATURE:** _____

Please return to: