School City of Hobart

Elementary Immunizations

STUDENT NAME LAST FIRST M.I		BIRTH DATE
GENDER	SCHOOL	GRADE

IMMUNIZATIONS: Health care provider must verify record. If a medical contraindication applies, State Form 54648 must be attached explaining the medical reason.

VACCINE/DOSE	1 MO DAY YR	2 MO DAY YR	3 MO DAY YR	4 MO DAY YR	5 MO DAY YR	6 MO DAY YR
Hepatits B						
DPT o DTaP						
Td or Pediatric **DT**						
Polio **Specify IPV or OPV**						
MMR						
Varicella						
Hepatitis A						
HIB						
Other – Specify Pneumococcal, Influenza, etc.						

Circle all that apply - Printed copy attached Immunization record found in CHIRP

Health care Provider (MD, DO, APN, FNP, PA) must sign below to verify immunization record above.

Signature **Date**

Address **Phone**

Alternative Proof of Immunity

1.History of Varicella (chicken pox) : *Physician documentation of disease history must include month and year*

Date of disease **Signature** **Date**

2. Laboratory confirmation *(Circle one and attach copy of lab report)*

Measles Mumps Rubella Hepatitis B Varicella Lab Results Date

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School City of Hobart

Elementary Physical Exam

STUDENT NAME LAST FIRST M.I	BIRTH DATE	GENDER	GRADE

HEALTH HISTORY: Parent or Guardian answer questions and sign below. Please explain all **YES** answers.

STUDENT HISTORY	YES	NO	EXPLAIN	STUDENT HISTORY	YES	NO	EXPLAIN
Asthma				Seizures or Epilepsy			
Blood Disorder				Skin problem			
Cardiac Problems				Urinary Problem			
Diabetes				Behavior Problem			
Ear/ Hearing Problem				Hospitalizations			
Eye/ Vision Problem				Surgery			
Gastrointestinal Problem				Serious Injury or Illness			
Bone or Joint Problem				Other Problems			

ALLERGIES (FOOD, DRUGS, INSECTS OR OTHER)

TYPE:	REACTION:

MEDICATION (List all prescribed, emergency, or over-the-counter)

NAME	DOSE	REASON

PHYSICAL EXAM – Health care provider complete and sign below

Height Weight B/P / Pulse

SYSTEMS REVIEW	NORMAL	ABNORMAL	COMMENTS
General Appearance			
Skin			
Eyes			
Ear, Nose, Mouth and Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurologic			
Endocrine			
Psychiatric			
Hematologic			

I approve this student's participation in recess and physical education (Circle what applies) YES NO MODIFIED

Explain modifications if needed:

Health care Provider (MD, DO, APN, FNP, PA) must sign

Signature **Date**

Address **Phone**

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