SCHOOL CITY OF HOBART

32 East 7th Street, Hobart, IN 46342
Phone: 219-942-8885 Fax: 219-942-0081
http://www.hobart.k12.in.us
"Building College and Career Ready Brickies"

2021-2022 Hobart Middle School
6th Grade Physical Exam & Immunization Information

Dear Parent/Guardian,

A physical exam is recommended for all students entering 6th grade at Hobart Middle School. A healthcare provider must complete the attached physical form. An athletic physical us also acceptable. All students who wish to participate in any extra-curricular athletic activity must have an annual physical stating they are cleared to participate.

The following additional immunizations are required for all incoming 6th grade students:

- **1 Tdap (tetanus and Pertussis)**
- **1 MCV4 Meningococcal conjugate)**
- **2 Hepatitis A (6 months between 1st and 2nd dose required)**

The full list of all school immunization requirements can be found online at https://chirp.in.gov/ or https://www.cdc.gov/vaccines/schedules/.

Physicals and immunizations are available at:
Brickie Community Health Clinic
2211 East 10th Street
Hobart, IN 46342
(219) 945-9383

Immunizations are also available at:
Lake County Health Department
2900 West 39rd Street
Crown Point, IN 46307
(219) 755-3658

***Reminder: Students need these vaccinates by the first day of school. Students without completed immunizations will be excluded from school.**

Sincerely,

Jamie Noel, R.N.
Coordinator of Student Health Services

School City of Hobart

Middle School Immunizations

STUDENT NAME LAST FIRST M.I	BIRTH DATE	GENDER	GRADE

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

CHECK ALL THAT APPLY : _____ **Printed copy attached** _____ **Complete Immunization record found in CHIRP**

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

Health care Provider (MD, DO, APN, FNP, PA) must sign to verify immunization record if hand written.

Signature **Date**

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**

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.

School City of Hobart

Middle School 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

Parent/Guardian Signature: **Date:**

PHYSICAL EXAM – Health care provider complete and sign below

Height **Weight** **B/P** / **Pulse**

Vision **R** 20/ **L** 20/ **Glasses** - Yes / No **Contacts** - Yes / No

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 physical education and all sports (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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