

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given			BOOSTERS & DATES												
	DOSES															
Diphtheria and Tetanus*	1	/	/	2	/	/	3	/	/	4	/	/	/	5	/	/
Polio	1	/	/	2	/	/	3	/	/	4	/	/	/	5	/	/
Measles, Mumps, Rubella	1	/	/	2	/	/										
Hepatitis B	1	/	/	2	/	/	3	/	/	4	/	/	/	5	/	/
HIB	1	/	/	2	/	/	3	/	/	4	/	/	/	5	/	/
Other _____																

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td

MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health

RELIGIOUS EXEMPTION (Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.)

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Report of Physical Examination (✓)

	Normal	Abnormal	If Abnormal, Explain
● Height (inches)			
● Weight (pounds)			
● Pulse ()			
● Blood Pressure /			
● Hair/Scalp			
● Skin			
● Eyes — Visual Acuity R ___ / ___ L ___ / ___			
● Eyes — Color Vision			
● Ears — Hearing dB R L			
● Nose and Throat			
● Teeth and Gingiva			
● Lymph Glands			
● Heart — Murmur, etc.			
● Lung — Adventitious Findings			
● Abdomen			
● Genitalia			
● Neuromuscular System			

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REPORT OF EXAMINATION

		TOOTH CHART																
		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No