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**

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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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