School City of Hobart

Elementary Immunization & Physical/Dental Examination

Please complete and return by the first day of school.

Date_____ School/Gr._____

Name_____Sex_____Birthdate_____

Address_____Phone_____

Past Medical History, Diseases, and Developmental History:_____

_____

Allergies_____

Medications_____

Other Health Issues/Chronic Conditions_____

Immunizations:

DTaP/DTP/DT #1_____#2_____#3_____#4_____

#5_____

IPV #1_____#2_____#3_____#4_____

MMR #1_____ #2_____

Hepatitis B #1_____#2_____#3_____

Varicella #1_____#2_____

Hepatitis A #1_____#2_____

Other_____

Physical Exam & Dental Exam on Back

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.

Physical Examination:

Height_____Weight_____Urine_____Glucose_____

Vision_____Ears_____Nose_____Tonsils_____

Lungs_____Spine_____Heart_____Nervous System_____

Skin/Scalp_____Orthopedic Defects_____

May this child take full participation in recess, gym activities and sports?_____

Recommendations or Restrictions_____

Medications & reason for taking_____

Chronic Conditions_____

Allergies_____

Date:_____

Examining Physician_____Phone_____

Dental Examination:

Condition of teeth and gums_____

Dental work required_____

Dental work completed_____

Date_____

Examining Physician_____Phone_____