St. Joseph School-School Immunization and Medical Form

Name_____ Date of Birth_____ Father's name_____ Mother's Name_____ .
Last First MI

Address_____ Guardian_____ Allergies_____ .

Phone Number _____ Chronic Ilness/Special Needs: _____ .

Disease History					
Chicken Pox	NO	YES		DATE	
Whooping Cough	NO	YES		DATE	
Rheumatic Fever	NO	YES		DATE	
Measels	NO	YES		DATE	
German Measels	NO	YES		DATE	
Mumps	NO	YES		DATE	
Scarlet Fever	NO	YES		DATE	
Other serious Illness or Surgery:					

Comments:

IMMUNIZATIONS	
DTP/DTp/	1.
DT/Td	2.
	3.
	4.
	5.
Tdap	6.
Menactra/MCV4	
Polio	1.
	2.
	3.
	4.
Hepatitis B	1.
	2.
	3.
Hepatitis A	1.
	2.
MMR	1.
	2.
Varicella	1.
	2.
Hib	Prevnar(PCV)
1.	1.
2.	2.
3.	3.
4.	4.
HPV	1.
	2.
	3.
Flu/H1N1	
TB Test	

Vision Screening

Date of Exam:

Glasses (Y/N)

Comments:

Physical Exam

Height	
Weight	
Nutrition	
Skin	
Allergies	
Blood Pressure	
Eyes	
Ears	
Nose	
Throat	
Lymph Gland	
Heart	
Lungs	
Genitalia	
Abdomen	
Hernia	
Extremities	
Posture/Scoliosis	

Comments:

Dental Exam

Date of Exam:

Comments:

Physician Name & Phone:

Dentist Name & Phone:

Codes: 0 = No Defect CB = Color Blind Testing R = Referral Sent W = Watch