

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 Illness/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) _____

Physical Exam

Height _____

Weight _____

Nutrition _____

Skin _____

Allergies _____

Blood Pressure _____

Eyes _____

Ears _____

Nose _____

Throat _____

Lymph Gland _____

Heart _____

Lungs _____

Genitalia _____

Abdomen _____

Hernia _____

Extremities _____

Posture/Scoliosis _____

Dental Exam

Date of Exam: _____

Physician Name & Phone: _____

Dentist Name & Phone: _____

Comments:

Comments:

Comments:

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