

Student's Name _____ Grade _____

MEDICAL HISTORY
(to be completed by parent)

Please share all information/medication. If an emergency arises, the school nurse needs complete information to inform EMS. This information will not be shared with anyone else unless you give your specific approval. See below.

1. Health conditions (ie asthma, diabetes, etc) or Health problems that may affect classroom work or Project Adventure participation (ie vision, hearing, physical limitations) _____

Based on the above information, I give my permission for my child to participate in Project Adventure on a limited basis only. _____ (initial)

*please specify these limitations. _____

OR

My child does not have any health conditions that may affect his/her participation in Project Adventure and I give my permission for my child to participate in Project Adventure as tolerated. _____ (initial)

2. Medications taken regularly or frequently by the student (prescription or over the counter) _____

Comments: _____

— Please review and sign either statement. —

I give my permission to the school nurse to share this information only with the Division Head and faculty members that come into regular contact with my child for the sole benefit of enhancing my child's education.

Parent's signature _____

OR

I do NOT give my permission to the school nurse to share this information at the present time.

Parent's signature _____

To be completed for Grades PK-5

PHYSICAL

(To be filled out by doctor)

Student Name: _____ Grade: _____

Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____

List Dates for Last: Tetanus Shot _____ Measles Immunization: _____

		SYSTEM	NORMAL	ABNORMAL	INITIALS
LIMITED	HEART				
	LUNG				
	OTHER				
	ABDOMINAL				
	GENITALIA				
COMPLETE	NECK				
	SHOULDER				
	WRIST				
	HAND				
	ELBOW				
	BACK				
	KNEE				
	ANKLE				
	FOOT				
	EYE		RIGHT 20/	LEFT 20/	CORRECTED? YES/NO

Comments: _____

Clearance:

- _____ A. Cleared for physical education/sports
- _____ B. Cleared after further evaluation/treatment
- _____ C. Not cleared for: ___ Collision ___ Contact ___ Noncontact

Recommendations: _____

Name of physician: _____

Address: _____

Telephone Number: _____

Signature of Physician

Date

This physical expires 1 year from the last day of the month that is was signed and dated. Must be signed after May 1, 2011

IMMUNIZATION RECORD

GRADES PRE-K - 5

(COMPLETED BY PHYSICIAN/NURSE)

Name _____ DOB ____/____/____ Grade _____

As of the first day of school, students **ages 4 through 10** must provide evidence of having received the following vaccines:

DTap: 4 or 5 doses with the last dose administered on or after age 4

MMR: 2 doses; 1st at 12 - 15 months, 2nd on or after age 4

Polio: 3 or 4 doses with the last does administered on or after age 4

Varicella: 2 doses or history of disease

Hepatitis B (HBV): 3 doses

Students ages **11 and older** must provide evidence of having received the following vaccines:

All of the above mentioned immunizations as well as:

Tdap: Tetanus Diptheria Acellular Pertussis vaccine

MCV-4: Meningococcal vaccine

	VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
*	DTP, DT, Tdap					
*	MMR			/	/	/
*	POLIO					
*	VARICELLA CHICKEN POX				Had disease - year _____	
*	HEPATITIS B				/	/
*	MCV-4					
	HIB					
	HPV					
	MENACTRA					
	TB					

* REQUIRED

I agree that the above immunizations are correct to the best of my knowledge.

SIGNATURE OF PHYSICIAN/NURSE _____

ADDRESS: _____

PHONE: _____ DATE: _____