

RETURN THIS FORM ONLY IF MD DOES NOT PROVIDE OWN FORM

SCHOOL CERTIFICATE OF HEALTH

(Verification of health status from a child's healthcare provider is required yearly and is due by the first day of school.)

Today's Date _____

Last Name: _____ First Name: _____ DOB: ____ / ____ / ____

Immunization Record

	#1	#2	#3	#4	#5
DPT	_____	_____	_____	_____	_____
OPV/IPV	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
HepB	_____	_____	_____	_____	_____
VARIVAX	_____	_____	_____	_____	_____

History of Chickenpox Date: : _____

Td Date: _____

Pb Date: _____

OTHER _____

Date of Routine Health Assessment: _____

Height _____ cm/in Weight: _____ kg/lb BP: _____

Tb exposure risk: Low _____ High: _____ PPD _____ Hgb/Hct: _____

Allergies: _____ EpiPen? Yes _____ No _____

Daily medications? 1. _____ 2. _____

The above-named patient has been examined and is free from any acute or chronic illness unless noted below. She or he may attend school and participate in all athletic activities without limitations unless otherwise noted below:

Comments: _____

Primary Care Provider Name: _____

Address: _____

Phone: _____

Signature: _____ Date: _____