

**PHYSICIAN'S RECORD OF IMMUNIZATION AND PRE-ADMISSION EXAMINATION**

Child's Name.....Date of Birth.....Sex.....

Address.....  
(Street) (City/State) (Zip)

**IMMUNIZATIONS AND SCREENINGS**

**RECORD MONTH/DAY/YEAR**

D.O.B.	Date	Date	Date	Date	Date	Date
DPT (Diphtheria, Tetanus, Pertussis)						
DT (Pediatric Diphtheria, Tetanus)						
DTaP						
Hepatitis B						
HIB (note type)						
Lead Screening (date)						
Lead Screening (results)						
Measles						
MMR (Measles, Mumps, Rubella)						
Mumps						
Polio						
PPD (date)						
PPD (result) read in MM						
Rubella						
Td (Adult Tetanus Diphtheria)						
Tetanus						
Varicella (Chicken Pox)						

Height.....Weight.....Blood Pressure.....

Date of Physical Examination:.....

Were there any abnormalities?  YES  NO

Please Specify:.....  
 .....  
 .....

Any obesity problem?  YES  NO

Visual Acuity?	<i>Right Eye</i>	<i>Left Eye</i>
	<input type="text"/>	<input type="text"/>
Glasses Needed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Hearing Screening?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Degree of Loss.....
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Teeth: Decayed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Missing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Filled?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Can this child participate in the usual school activities?  YES  NO

Please specify:.....  
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(Physician's Signature) - (Date)

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physician's address - street, city/state, zip telephone no.