LAST NAME (print)	FIRST NAME	MIDDLE NAME	DATE OF BIRTH		
			Month	Day	Year
			I.D. #		

IMMUNIZATION HISTORY

EXEMPT: (DOCUMENTATION MUST BE ATTACHED) RELIGIOUS _____ MEDICAL _____

DPT or DT or TD _____ _____ _____ _____ _____
Date Date Date Date Date

POLIO _____ _____ _____ _____ _____
Date Date Date Date Date

MMR _____ MEASLES* _____ MUMPS* _____ RUBELLA* _____
Date Date Date Date

HIB _____ (Pre-K attendees only)
Date

OTHERS _____ _____ _____
(Type & Date) (Type & Date) (Type & Date)

Signature of Preparer _____ Date** _____

*WHEN APPROPRIATE MEDICAL DOCUMENTATION INDICATES THAT THE STUDENT HAD THE DISEASE, ATTACH COPY OF DOCUMENTATION.

**ALL INFORMATION ENTERED SUBSEQUENT TO THIS DATE MUST BE INITIALED.

_____implant

Mantoux PPD _____ read ☐ Negative _____mm ☐ Positive _____mm Chest x-ray _____
Date Date

PHYSICAL EXAMINZATIONS

New Admission Physical Completed _____
Date

Additional Physical Exams _____

_____

_____

Chronic Health Problems or restrictive conditions reported: _____

_____