

HEALTH & IMMUNIZATION FORM

Please have this form completed by the student's physician.

Student's name: _____ DOB _____ Grade _____

Vision: Right _____ Left _____ Height: _____ Weight: _____ Hearing: Right _____ Left _____

Blood Pressure: _____ Date of last DT: _____ Age: _____ Tanner: I. II. III. IV. V.

Tdap _____ (enrolling in 6th, on or after 9/1/07 and are 11 years old)

Varicella _____ (required for students born on or after 1/1/94 and are enrolled in 6th grade)

Hepatitis B Vaccine Dates: 1. _____ 2. _____ 3. _____

Eyes: _____	Abdomen: _____
Ears: _____	Ortho. Posture: _____ scoliosis: _____
Nose/Sinus: _____	Nervous System: _____
Mouth/Teeth: _____	Skin: _____
Throat: _____	Feet: _____
Thyroid: _____	Nutrition: _____ BMI: _____
Heart: _____	Wt. status category: (BMI%) _____
Lungs: _____	Allergies: _____

Student may participate in:

All physical education classes	Yes	No
Intramural competitive athletics	Yes	No
Interscholastic competitive athletics	Yes	No

Parent /Guardian: Please check the sports/activities below that your student is interested in participating.

Doctor: Please indicate your approval or disapproval of participation in these sports/activities.

<u>Sport</u>	<u>Doctor</u>	<u>Sport</u>	<u>Doctor</u>
Football	Y N	Track	Y N
Baseball	Y N	Cross Country	Y N
Basketball	Y N	Skiing	Y N
Soccer	Y N	Volleyball	Y N
Hockey	Y N	Tennis	Y N
Softball	Y N	Bowling	Y N
Gymnastics	Y N	Golf	Y N
Cheerleading	Y N	Field Events	Y N

Are there any Physical Education restrictions or warnings we should be aware of? Yes No
 (If yes, please specify) _____

If the student is unable to participate in any of the above sports/activities, please indicate the disqualifying conditions: _____

Doctor's Name: _____ Date of Exam: _____

Doctor's Signature: _____ Phone #: _____