HOLY SPIRIT SCHOOL

MEDICAL FORM
(To Be Completed By Physician)

Name:_____ Grade _____

HEALTH HISTORY: Sex: ____M ____F D.O.B._____

Chronic Illnesses/Contagious Diseases_____

Allergies_____ Speech Issues_____

Injuries/Operations_____

Congenital or Physical Conditions_____

Vision or Hearing Deficits_____

IMMUNIZATIONS REQUIRED BY N.J. STATE DEPARTMENT OF HEALTH

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*						Test Date	Result
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted:_____ ☐ Medical exemption attached ☐ Religious exemption attached

PHYSICAL EXAMINATION REPORT:

Ht_____Wt_____Blood Pressure_____Pulse_____

Vision: R 20/___ L 20/____ Corrected? Yes/No Hearing: R____ L____

Medical & Developmental Findings:_____

Prescribed Medications (Include Epi Pens or Inhalers): _____

Modifications in Child's Program:_____

Gym or School Sports Restrictions: _____

Examined by: Dr._____

Address:_____

Phone No:._____Date of Exam:_____

This Form Must Be Completed Before Your Child Can Attend School