

KOKOMO/HOWARD COUNTY SCHOOLS

Sts. Joan of Arc and Patrick School

LAST NAME FIRST NAME MI BIRTHDATE MALE/FEMALE

PARENT/GUARDIAN ADDRESSSS PHONE

TO BE COMPLETED BY PARENT OR GUARDIAN:

HEALTH AND IMMUNIZATION HISTORY: Give a brief history of any serious accident, operation and/or health conditions (such as rheumatic fever, asthma, diabetes, seizure, vision and/or hearing problems) of your child. Please include ALLERGIES:

MEDICATIONS:

RECORD OF IMMUNIZATIONS (LIST MONTH-DAY-YEAR)

DT/DPT/DTAP 1. 2. 3. 4. 5. MMR 1. 2.

OPV/IPV 1. 2. 3. 4. 5. TB TEST: TINE/MANTOUX RESULT

HIB 1. 2. 3. 4. HEP B 1. 2. 3. VARICELLA

MEDICAL SCREENING BY PHYSICIAN RECOMMENDED: To be completed by physician: CODE: O = no defect + = defect found

1. General appearance 2. Eyes 3. Ears/nose/throat 4. Mouth & teeth 5. Lymph nodes 6. Heart

7. Lungs 8. Abdomen 9. Genitals 10. Posture & feet 11. Gait 12. Nervous systems

13. Musculo-skeleton 14. Skin

BP Height Weight Recommended Tests: Hemoglobin Urinalysis Sickle Cell

This pupil (may - may not) participate in Physical Education. LIMITATIONS:

Physician's Note:

Physician's signature DATE:

IMMUNIZATION REQUIREMENTS FOR CHILDREN ENTERING KINDERGARTEN:

DPT/DT/DTAP: 5 DOSES OPV/IPV: 4 DOSES MMR: after 12 months of age: 2 doses HEP B: 3 DOSES

TB TEST (TINE OR MANTOUX); one recommended before entering school VARICELLA: NOT REQUIRED