MESSIAH
LUTHERAN SCHOOL

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SCHOOL ENTRANCE MEDICAL RECORD

TAKE THIS TO YOUR PHYSICIAN

School: _____ Grade: _____
Name of Child: _____ Birthdate: _____
Address: _____

EXAMINATION

Date: _____ Height: _____ Weight: _____
Eyes: _____ Vision: R. 20/_____ L. 20/_____
Ears: _____ Hearing Test: Type: _____R _____ L _____
Referred to ear/eye specialist? Yes _____ No _____
Nose: _____ Throat: _____
Mouth: _____ Teeth: _____
Is dental work indicated: Yes _____ No _____ If so, are plans being made? Yes _____ No_____
Posture: _____ General Condition: _____
Skin: _____ Orthopedic: _____
Neck: _____ Nervous System: _____
Heart: _____ Lungs: _____
Abdomen: _____ Hernia: _____
Genitalia: _____ Urinalysis: _____
Mental/Developmental Health: _____
Remarks and Recommendations: _____
_____

IMMUNIZATIONS – (Please list exact dates or attach history)

DTaP (Diphtheria, Tetanus, Whooping Cough): **5 DOSES REQUIRED** (unless 4th after 4th birthday, then 4 required)
1. _____ 2. _____ 3. _____4. _____ 5. _____
Polio: **4 DOSES REQUIRED** (unless an all IPV or all OPV sequence was used 3rd was after 4th birthday, then 3 required)
1. _____ 2. _____ 3. _____4. _____ 5. _____
MMR (Measles, Mumps, Rubella): **2 DOSES REQUIRED**
1. _____ (must be given after 1st birthday)
2. _____ (must be given at least 1 month after 1st does)
Varicella (Chicken Pox)
1. _____
2. _____
Hepatitis B: **3 DOSES REQUIRED** (2nd dose at least 1 month after 1st; 3rd dose at least 2 months after 2nd dose & follow 1st by at least 4 months and not before age 6 months, or a 4th dose is needed)
1. _____2. _____3. _____ 4. _____
Hib: (haemophilus b) _____Other _____
Latest Tuberculin Test: Type _____ Date _____ Positive _____ Negative _____
Annual Influenza _____ (Preschool requirement)
HepA: **2 DOSES REQUIRED** 1. _____ 2. _____ (Preschool requirement)
PCV: **4 DOSES REQUIRED 1.** _____ 2. _____ 3. _____ 4. _____
Tdap _____ (Mcv4) _____
(Required for 7th grade) (Required for 7th grade)

I CERTIFY THAT THIS CHILD HAS HAD THE ABOVE IMMUNIZATIONS

_____ _____
Date Signature of Physician

_____ _____
Date Signature of Parent

06/2018