CLINTON PRAIRIE ELEMENTARY SCHOOL
Kindergarten Medical Form and Immunization Record
Due at School by July 15, 2016

Fax: 765-659-9560

Name _____ **Birth Date** _____

PARENTS – Please check if child has or has had any of the following:

	Rubella		Scarlet Fever		Diabetes		Hearing Problems
	Rubeola		Allergy		Heart Disease		Speech Difficulty
	Mumps		Anemia		Seizures		Vision Problems
	Whooping Cough		Asthma		Faints Easily		Frequent Nosebleeds

Give a brief history of any items checked above: _____
_____

Give a brief history of any serious accident, operation and/or health condition: _____
_____
_____

Is your child on any daily medication? Please list medication, dose and times:
_____
_____
(In the future, if your child is placed on medication, please inform the Nurse's Office.)

_____
Parent Signature Date

YOUR CHILD SHOULD HAVE A MEDICAL EXAMINATION PRIOR TO STARTING KINDERGARTEN

Date of Exam _____ Height _____ Weight _____
Temperature: _____ Pulse _____ Urinalysis _____

Area/System	Normal	Abnormal	Pertinent Findings
Heart/Cardiovascular			
Lungs/Respiratory			
ENT/Tonsils			
Eyes			
Abdomen			
Skin			
GU			
MS/Neuro			

IMMUNIZATIONS REQUIRED BY LAW

Vaccine	Date Given	Date Given	Date Given	Date Given	Date Given
DPT/DTaP					
OPV/IPV					
MMR					
Hepatitis B					
Varicella			Or:Month & year of Chicken pox_____		
Hepatitis A					

OTHER IMMUNIZATIONS

HIB					
Prevnar/PCV7					
Other					

(Optional)
TB Skin Test

_____
Date Given

_____
mm Indur

_____
Physician Signature

Revised March 2016