RADNOR TOWNSHIP SCHOOL DISTRICT
Wayne, Pennsylvania

School:_____ School Year: _____

This portion to be completed by <u>PARENT:</u>
Name of Student _____ Sex M_____ F ____Grade _____

Address of Student_____Date of Birth _____

School Last Attended _____Physician's Name _____

Has your child had any of the following? Please check and give details or date.
Allergies _____ Mumps _____Scarlet Fever _____
Asthma _____ Measles_____Diabetes _____
Chicken Pox _____ Rubella _____Operation _____
Recurring Illness _____ Physical Disability _____

Is your child at present under medical treatment? Yes No If yes, please explain.

_____

This portion to be completed by <u>PHYSICIAN:</u>
Required immunization dates (details on reverse side).

VACCINE	BASIC SERIES DATES OF DOSES and BOOSTERS				
Diphtheria and Tetanus DtaP, DPT, DT or Td	1	2	3	4	5
Tetanus, Diphtheria and Acellular Pertussis (Tdap)	1	2	3	4	5
Polio (OPV or IPV)	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	or Measles serology: Date Titer		
Varicella (Vaccine or Disease)	1	2	Rubella Serology: Date Titer		
Meningococcal (MCV)	1	2			
Other	1	2	Mumps disease diagnosed by a physician: Date		

Tuberculosis Test:_____ Date_____ Result_____

Medical History - Operations, accidents, allergies, serious illness. Specify and give dates.

Present medication:

<u>Findings upon Physical Examination:</u>
Blood Pressure _____Pulse _____Height _____ Weight _____ BMI #_____/_____%

Is this BMI in recommended range? Yes _____ No _____ Was counseling initiated? **Yes** _____ **No** _____

Is scoliosis present? Yes____ **no**____ Under care?_____

<u>Vision</u>: - Far – Right _____ Near – Right _____ <u>Hearing</u>: Right _____ Left _____
Left _____ Left _____
OU _____ OU _____

Should this student have any restriction on physical education activities? **No** ____ **yes** ____If **yes**, please specify.

What recommendations do you wish to make to teachers or nurses which might benefit this child at school?

_____
Signature of Physician Address Telephone # Date