

**BLUFFTON-HARRISON MSD  
KINDERGARTEN HEALTH RECORD FORM**

**Please return the completed form to the school Nurse by the first day of school.**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**IMMUNIZATION RECORD**

**Immunizations are required for enrollment by Indiana law. Minimum immunizations for students enrolled in kindergarten include the following: 5 Diphtheria-Tetanus-Pertussis (DTaP/DTP); 4 Polio (IPV); 2 Measles, Mumps, Rubella (MMR); 3 Hepatitis B; 2 Hepatitis A; and 2 Varicella (or history of chickenpox disease documented with physician signature).**

**(Physician/Health Dept.: Please document month, date, and year; or copy the immunization record.)**

DTaP/DTP #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

IPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_

Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_

Varicella #1 \_\_\_\_\_ #2 \_\_\_\_\_

(or date of chicken pox disease \_\_\_\_\_ **Physician** signature \_\_\_\_\_)

Date \_\_\_\_\_ Physician or Health Department Signature \_\_\_\_\_

**Health Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Musculoskeletal \_\_\_\_\_

Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Throat \_\_\_\_\_

Heart \_\_\_\_\_ Lungs \_\_\_\_\_

Blood pressure \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_

Known Allergies \_\_\_\_\_

Current medications: \_\_\_\_\_

Special health needs \_\_\_\_\_

Recommendations:

Date \_\_\_\_\_ Physician signature \_\_\_\_\_