THAYER ACADEMY COLLABORATIVE
Medical Report of Physical Exam and Immunizations

**NOTE:* *An Equivalent Form (Provided by your Physician) May Be Used in Place of This Form.*

Student Name: _____ _____ ☐ Male ☐ Female Date of Birth: ___/___/___
Last *First* MO. DAY YR.

I. IMMUNIZATIONS

Hepatitis B

☐ 3-dose or ☐ 2-dose series

DATE
1 ___/___/___
2 ___/___/___
3 ___/___/___

☐ Serologic Proof of Immunity
DATE ___/___/___

MMR

DATE
1 ___/___/___
2 ___/___/___

☐ Serologic Proof of Immunity
DATE
☐ Measles ___/___/___
☐ Mumps ___/___/___
☐ Rubella ___/___/___

DTaP/DTP/DT

DATE
☐ DTaP/DTP or ☐ DT 1 ___/___/___
☐ DTaP/DTP or ☐ DT 2 ___/___/___
☐ DTaP/DTP or ☐ DT 3 ___/___/___
☐ DTaP/DTP or ☐ DT 4 ___/___/___
☐ DTaP/DTP or ☐ DT 5 ___/___/___

Td (Booster)

DATE
1 ___/___/___
2 ___/___/___
3 ___/___/___
4 ___/___/___
5 ___/___/___

Varicella

DATE
1 ___/___/___
2 ___/___/___

☐ Serologic Proof of Immunity
DATE ___/___/___

☐ **Chickenpox History** DATE ___/___/___
Check the box if this person has
a physician-certified reliable history based on:
- physician interpretation of parent/guardian description of chickenpox; or
- physician diagnosis of chickenpox.

Polio

DATE
☐ IPV or ☐ OPV 1 ___/___/___
☐ IPV or ☐ OPV 2 ___/___/___
☐ IPV or ☐ OPV 3 ___/___/___
☐ IPV or ☐ OPV 4 ___/___/___
☐ IPV or ☐ OPV 5 ___/___/___

HIB *(Preschool only)*

DATE
1 ___/___/___
2 ___/___/___
3 ___/___/___
4 ___/___/___

Lead Screening *(Kindergarten only)*
DATE ___/___/___ *Level:* _____

TB Risk Screening

☐ Low Risk: PPD not required
☐ **High Risk: PPD required**
DATE (mm)
PPD: ___/___/___ Results: Neg Pos _____
Follow-up: _____

II. MEDICAL HISTORY

Allergies: _____
_____ ☐ **Requires EpiPen**
Medical conditions: _____
_____
Mental health concerns: _____
Current medications: _____
_____

III. PHYSICAL EXAM

Date of exam: ___/___/___ ☐ **WNL** *(unless noted below)*
Height: _____ inches; Weight: _____ pounds; P: _____ ; BP: _____
Vision: Left _____ Right _____ ☐ Glasses/Contacts
Hearing: Left _____ Right _____
Postural: ☐ WNL; ☐ Abnormal _____
Comments:

IV. MEDICAL CLEARANCE

Based on the physical exam and medical assessment, noted above, the student may participate in all physical activities and sports
☐ without restriction, or ☐ with the following restriction(s): _____

☐ Physician or ☐ PNP: *(Print Name)* _____ *(Signature)* X _____
Facility: _____ Address: _____
Office Tel #: _____ Office Fax #: _____ Date of form completion: ___/___/___