

School City of Hobart

Elementary Immunizations

STUDENT NAME		BIRTH DATE
LAST	FIRST	M.I
GENDER	SCHOOL	GRADE

IMMUNIZATIONS: Health care provider must verify record. If a medical contraindication applies, State Form 54648 must be attached explaining the medical reason.

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
Hepatitis B																		
DPT o DTaP																		
Td or Pediatric DT																		
Polio Specify IPV or OPV																		
MMR																		
Varicella																		
Hepatitis A																		
HIB																		
Other – Specify Pneumococcal, Influenza, etc.																		

Circle all that apply - Printed copy attached Immunization record found in CHIRP

Health care Provider (MD, DO, APN, FNP, PA) must sign below to verify immunization record above.

Signature _____ Date _____

Address _____ Phone _____

Alternative Proof of Immunity

1. History of Varicella (chicken pox) : Physician documentation of disease history must include month and year

Date of disease _____ Signature _____ Date _____

2. Laboratory confirmation (Circle one and attach copy of lab report)

Measles Mumps Rubella Hepatitis B Varicella Lab Results Date

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.

School City of Hobart

Elementary Physical Exam

STUDENT NAME			BIRTH DATE	GENDER	GRADE
LAST	FIRST	M.I			

HEALTH HISTORY: Parent or Guardian answer questions and sign below. Please explain all YES answers.

STUDENT HISTORY	YES	NO	EXPLAIN	STUDENT HISTORY	YES	NO	EXPLAIN
Asthma				Seizures or Epilepsy			
Blood Disorder				Skin problem			
Cardiac Problems				Urinary Problem			
Diabetes				Behavior Problem			
Ear/ Hearing Problem				Hospitalizations			
Eye/ Vision Problem				Surgery			
Gastrointestinal Problem				Serious Injury or Illness			
Bone or Joint Problem				Other Problems			

ALLERGIES (FOOD, DRUGS, INSECTS OR OTHER)

TYPE:	REACTION:
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MEDICATION (List all prescribed, emergency, or over-the-counter)

NAME	DOSE	REASON

PHYSICAL EXAM – Health care provider complete and sign below

Height	Weight	B/P	/	Pulse
SYSTEMS REVIEW	NORMAL	ABNORMAL	COMMENTS	
General Appearance				
Skin				
Eyes				
Ear, Nose, Mouth and Throat				
Cardiovascular				
Respiratory				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Neurologic				
Endocrine				
Psychiatric				
Hematologic				

I approve this student's participation in recess and physical education (Circle what applies)		YES	NO	MODIFIED
Explain modifications if needed:				
Health care Provider (MD, DO, APN, FNP, PA) must sign				
Signature			Date	
Address			Phone	

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