



MEDICAL INFORMATION AND IMMUNIZATIONS

Student's Name: _____ Birth Date: _____

FORM MUST BE RETURNED BEFORE STUDENT CAN ENTER LASALLE COLLEGE HIGH SCHOOL.

Allergies (food, dust, pets, medicines, etc.) _____

Serious illness _____

Chronic conditions _____

Needs while in school _____

Daily medications _____

(If needed while in school, please contact School Nurse.)

PLEASE PROVIDE A COPY OF THE STUDENT'S SHOT RECORD.

PENNSYLVANIA DEPARTMENT OF HEALTH REQUIRES ALL STUDENTS IN PUBLIC, PRIVATE AND PAROCHIAL SCHOOLS TO HAVE THE FOLLOWING IMMUNIZATIONS:

5 Doses of Tetanus & Diphtheria (DT/Td)

4 Doses of Polio

2 Doses of measles, mumps, and rubella

3 Doses of Hepatitis B

2 Doses of Varicella or evidence of immunity

1 Dose of Meningococcal Vaccine

I give the School Nurse my permission to share this information with school personnel when deemed necessary for my child's educational experience.

Date

Parent/Guardian Signature