SOUTHERN VALLEY SCHOOLS
MEDICAL EXAMINATION AND IMMUNIZATION RECORD

_____ Birth date ____/____/____ Boy / Girl
(Student's Name) (Circle One)

Immunizations: Please give dates and number of doses / **Those in bold required**

Polio: Type _____ Number of Doses ____ Dates _____ _____ _____ _____ _____

Diphtheria, Pertussis, Tetanus: Number of Doses ____ Dates _____ _____ _____ _____ _____

MMR: Number of Doses ____ Dates _____ _____ _____

Hepatitis B: Number of Doses ____ Dates _____ _____ _____

Varicella: Number of Doses ____ Dates _____ _____

Other Immunizations or Vaccinations: _____

HIB, Haemophilus, Influenza B: Number of Doses ____ Dates _____ _____ _____ _____ _____

Tuberculin Test: _____ Results: _____

Physical Examination: Height _____ Weight _____

Surgeries or major illnesses: _____

_____

Skin: Normal _____

Teeth: Good _____ Poor _____ Cavities: Yes / No (circle one)

Throat / Tonsils Normal _____ Enlarged _____ Cryptic ____ Absent _____

Glands: Normal _____ Cervical _____ Thyroid _____

Ears: Normal _____ Defective: Right _____ Left _____

Heart: Normal _____ Murmur: _____ Pulse _____ Blood Pressure _____

Lungs: Normal _____

Chest: Normal _____ Flat _____ Funnel _____ Pigeon _____

Abdomen: Normal _____ Distended _____ Hernia _____

Spine: Normal _____ Curvature _____ Round Shoulders _____

Posture: Good _____ Fatigue _____

Extremities: Upper _____ Lower _____

Feet: Normal _____ Flat: Right _____ Left _____

Hmg _____ **Het** _____ **UA** _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SOUTHERN VALLEY SCHOOLS

I hereby authorize release to Southern Valley Schools and/or the school nurse the information contained in this document.

Parents' Signature _____ **Date** _____

_____ _____

Physician's Signature ***Date***