SCHOLASTIC SUPPORT/ "SCHOOL'S OUT" REGISTRATION FORM

HEALTH & IMMUNIZATION RECORD

Please complete OR attach forms with all current information from your pediatrician.

Child's Name: _____ DOB: _____

Immunizations (date administered)

DTP _____ _____ _____ _____

POLIO _____ _____ _____

MMR _____

HIB _____ _____ _____

HBV _____ _____ _____

OPV/IPV _____ _____ _____

Varicella _____

Tuberculin Skin Test: **Date: _____results: _____**

Lead Screening: **Date: _____results: _____**

Health Examination: **Date: _____results: _____**

Does this child have any conditions or limitations, which the caregiver should be aware of, such as allergies, seizures, etc. (if yes, please specify)

_____

_____

_____ _____

Physician Signature Date