Medical Information Form

To be completed by the child's physician

______________________________ ______________________________

Student Name Date

We request this information to ensure our pupils a satisfactory school experience.
Thank you for your consideration in providing the following:

Immunizations Required		Dates Administered
Tetanus	(3 or 4 doses)	______________________________
Diptheria	(3 or 4 doses)	______________________________
Polio	(3 doses)	______________________________
Measles	(2 doses)	______________________________
Mumps	(1 dose)	______________________________
Rubella	(1 dose)	______________________________
Hepatitis B	(3 doses)	______________________________

Varicella (Chicken Pox - 1 dose or date of disease) ______________________________

****

Allergies ______________________________

Surgical procedures ______________________________

Any physical or emotional conditions of which we should be aware (parent or physician input):

____

____

____

____

Physician's Signature