

**CLINTON PRAIRIE ELEMENTARY SCHOOL  
Kindergarten Medical Form and Immunization Record  
Due at School by July 15, 2019**

**Fax: 765-659-9560**

**Name** \_\_\_\_\_

**Birth Date** \_\_\_\_\_

PARENTS – Please check if child has or has had any of the following:

<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Rubeola	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Speech Difficulty
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Faints Easily	<input type="checkbox"/>	Frequent Nosebleeds

Give a brief history of any items checked above: \_\_\_\_\_

Give a brief history of any serious accident, operation and/or health condition: \_\_\_\_\_

Is your child on any daily medication? Please list medication, dose and times:

(In the future, if your child is placed on medication, please inform the Nurse's Office.)

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**YOUR CHILD SHOULD HAVE A MEDICAL EXAMINATION PRIOR TO STARTING KINDERGARTEN**

Date of Exam \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Temperature: \_\_\_\_\_ Pulse \_\_\_\_\_ Urinalysis \_\_\_\_\_

Area/System	Normal	Abnormal	Pertinent Findings
Heart/Cardiovascular			
Lungs/Respiratory			
ENT/Tonsils			
Eyes			
Abdomen			
Skin			
GU			
MS/Neuro			

**IMMUNIZATIONS REQUIRED BY LAW**

Vaccine	Date Given	Date Given	Date Given	Date Given	Date Given
DPT/DTaP					
OPV/IPV					
MMR					
Hepatitis B					
Varicella					
Hepatitis A					

(Optional)  
 TB Skin  
 Test  
 \_\_\_\_\_  
 Date Given  
 \_\_\_\_\_  
 mm Indur

**OTHER IMMUNIZATIONS**

HIB					
Prevnar/PCV7					
Other					

Physician Signature \_\_\_\_\_