

CLINTON PRAIRIE ELEMENTARY SCHOOL
Kindergarten Medical Form and Immunization Record
Due at School by July 15, 2021

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"/>	COVID-19	<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 G (Optional)
DPT/DTaP					
OPV/IPV					
MMR					
Hepatitis B					
Varicella					
Hepatitis A					

OTHER IMMUNIZATIONS

HIB					
Pevnar/PCV7					
Other					

Physician Signature _____