St. Charles Borromeo Catholic School

260-484-3392
Fax (260) 482-2006
nurse@stcharlesschoolfw.org

Our Mission: To Teach, Love, Live, and Learn as Jesus Did
Our Vision: Share Faith, Serve Others, Seek Knowledge

PHYSICIAN CERTIFICATE OF EXAMINATION

(To be completed by your child's physician)

Student Name _____ Date of Birth _____/_____/_____

Allergies _____

Severe Allergies _____

Current Medications

1. _____ Dosage _____ How often _____
2. _____ Dosage _____ How often _____
3. _____ Dosage _____ How often _____

Height _____ Weight _____ B/P _____ Pulse _____

Eyes _____
Ears _____
Nose _____
Throat _____
Chest/Lungs _____
Heart _____
Abdomen _____
Hernia _____
Extremities _____
Musculoskeletal _____
Neurological _____
Skin _____

Lab Work (If indicated)
Hematocrit _____
Hemoglobin _____
Lead Level _____
Sickle Cell _____
Urinalysis _____
Other _____

Is this student physically fit to participate in all physical education programs?

Yes _____ No _____ If no, please explain: _____

_____

Please list any conditions that should be considered in planning this child's school day:

_____

_____

CONTINUED ON REVERSE

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IMMUNIZATION HISTORY

PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All students must have an immunization record in the school office before the first day of school. This student MAY NOT attend school without a record of having received the required immunizations listed below. The only exception is to have a medical or religious exemption form filed with the school office.

The following immunizations are the minimum requirements by the State of Indiana for

Kindergarten - 4th Grades

DTaP (5)
IPV (4)
Hepatitis B (3)
MMR (2)
Varicella (2)
Hepatitis A (2)

5th Grade

DTaP (5)
IPV (4)
Hepatitis B (3)
Hepatitis A (2)
MMR (2)
Varicella (2)

6th Grade

Previous listed plus an additional Tdap (1),
MCV (1)
Hepatitis A (2)

7th Grade

Hepatitis A, 2 doses given 6 months apart

8th Grade

Previously listed, but Hepatitis A is required

(These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.)

_____

Printed or Stamped name of the physician completing this form

_____

Physician's signature **Date**