

MATER DEI ACADEMY GRADES K-8  
IMMUNIZATION RECORD

Name \_\_\_\_\_ Address \_\_\_\_\_ Birthdate \_\_\_\_\_

**\*\* Attach immunization record or provide dates below per ORC 3313.37/3313.671**

**DTap** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_ **Tdap** \_\_\_\_\_

**Polio Vaccine** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

**MMR** #1 \_\_\_\_\_ #2 \_\_\_\_\_ **Varicella** #1 \_\_\_\_\_ #2 \_\_\_\_\_

**HIB** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

**Rotavirus** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Hepatitis B** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ **Hepatitis A** #1 \_\_\_\_\_ #2 \_\_\_\_\_

**Pneumococcal** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ **Meningococcal** \_\_\_\_\_

PHYSICAL EXAMINATION RECORD

Pupils enrolled for the first time must have a physical exam per ORC 3313.673.

**Date of Exam:** \_\_\_\_\_ **SEX: Male** \_\_\_\_\_ **Female** \_\_\_\_\_

Height		<b>Recommended Assessments/Screenings</b>			
Weight		<i>See attached form</i>	Lead	<input type="checkbox"/> yes	<input type="checkbox"/> no
Blood Pressure			Hemoglobin	<input type="checkbox"/> yes	<input type="checkbox"/> no
BMI			Dental	<input type="checkbox"/> yes	<input type="checkbox"/> no

NORMAL	ABNORMAL		Comments:
		Head, face and scalp	
		Teeth	
		Nose and sinus	
		Eyes	Allergies:
		Ears	
		Mouth and Throat	
		Neck (Thyroid)	
		Chest and Lungs	Medications:
		Heart	
		Abdomen	
		Genitalia	
		Back, Extremities	Restrictions regarding physical sports or activities:
		Skin	
		Rectum, Anus	
		Neurological	

**PLEASE PRINT OR STAMP**

**Physician's Name** \_\_\_\_\_ **Physician's Signature** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Date Signed** \_\_\_\_\_