

Mount Vernon Academy

P.O. Box 311 - 525 Wooster Rd. ~ Mount Vernon, OH 43050

Phone (740) 397-5411 ~ Fax (740) 397-3901

PHYSICIAN'S EXAMINATION & IMMUNIZATION RECORD

Student Name _____ Date of Birth _____

Note: This is to be completed by your physician and MUST include immunizations. Please take student's early morning urine specimen to the doctor's office on the day of the examination.

1. Does this student have any physical health problems? _____
Cardiac Asthma Allergies Convulsive Disorders Blood Dyscrasia Diabetes Neurologic
2. Does this student have any problems which might influence his school adjustment? _____

3. Is there any physical defect or illness which should restrict the student's activities at school in any way? _____

4. List any medication the student should take while at school _____

5. This student should continue under medical care for the conditions specified: _____

	Measurement	Under Care		Normal		Referred	
		Yes	No	Yes	No	Yes	No
Height							
Weight							
Blood Pressure							
Vision Deficiency							
Hearing Deficiency							
Speech Problem							

Additional Comments _____

Physician's Signature _____ Date _____

IMMUNIZATION RECORD

Immunizations	Minimum Required	Series (day/month/year)	Booster	
DTP or Td (Diphtheria, Tetnus, Pertussis)	Infant series of 5 boosters before 4 th birthday. Td booster every 10 years thereafter	/ /	/	/
		/ /	/	/
		/ /	/	/
Oral Polio Vaccine	Infant series of 3 boosters	/ /	/	/
		/ /	/	/
		/ /	/	/
Measles Vaccine	Disease if verified by physician OR 2 doses before 7 th grade	/ / (disease)	#1	/ /
			#2	/ /
Rubella Vaccine	Disease if verified by physician OR 2 doses before 7 th grade	/ / (disease)	#1	/ /
			#2	/ /
Mumps Vaccine	Disease if verified by physician OR 2 doses before 7 th grade	/ / (disease)	#1	/ /
			#2	/ /

For immunizations still needed, please take this form with you to the doctor or health dept. If it is necessary for the student name above to have immunizations while at Mount Vernon Academy, please sign the following: *I give permission for the student named above to have needed immunizations at MVA through Knox County Health Department.* (Note: A minimal immunization fee is charged by the KCHD)

Parent/Guardian Signature _____ Date _____