

ST. PAUL'S LUTHERAN SCHOOL  
 PHYSICIAN'S CERTIFICATE  
 TUBERCULIN SKIN TEST FOR SCHOOL ENROLLMENT  
 (Chapter 150, Acts 1969, and Regulation HTO Immunization Requirements for School Enrollment)  
 (House Enrolled Act #1352)

Please print

Student's Last Name	First	Middle	
Street Address	City	State	
Birthdate	Grade	Sex	Race
Parent/Guardian	Phone Number		

**DISEASE/IMMUNIZATION HISTORY**

Disease	Date	Immunizations	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
Chicken Pox		Diphtheria Pertussis	1	2	3	4	5
German Measles		Tetanux	1	2	3	4	5
Mumps		Oral Poliomyelitis	1	2	3	4	
Rheumatic Fever		Measles	1	2			
Scarlet Fever		Mumps	1				
Whooping Cough		Rubella	1				
		Hepatitis B	1	2	3		
		Varicella (Chicken Pox)	1				
Others (specify)		Tuberculin Test Date If given	1	Negative Positive			
		Hemophyllis (HIB Vaccine)	1	2	3	4	



Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_ M.D.

Physician's Printed Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

PHYSICIAN'S EXAMINATION RECORD

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

Physical and Nutritional Development \_\_\_\_\_ Mental and Emotional Development \_\_\_\_\_

SKIN \_\_\_\_\_ HEAD Hair and Scalp \_\_\_\_\_

B/P \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

NOSE AND THROAT \_\_\_\_\_ CHEST \_\_\_\_\_  
Palpable Nodes \_\_\_\_\_ Tonsils \_\_\_\_\_ Lungs \_\_\_\_\_ Heart \_\_\_\_\_

ABDOMEN \_\_\_\_\_  
Hernia \_\_\_\_\_ Inguinal \_\_\_\_\_ Femoral \_\_\_\_\_ Umbilical \_\_\_\_\_ Other \_\_\_\_\_

EXTREMITIES \_\_\_\_\_

ORTHOPEDIC DEFECT \_\_\_\_\_

Operations (Specify): \_\_\_\_\_

Serious Accidents: \_\_\_\_\_

Child Suffers from: Allergy \_\_\_\_\_ Asthma \_\_\_\_\_ Epilepsy \_\_\_\_\_ Tonsillitis \_\_\_\_\_ Other (specify) \_\_\_\_\_

I recommend the **regular school program** \_\_\_\_\_  
(If there is anything about this child's condition that will influence or interfere with regular school life, please note)

I recommend the **regular program of physical activity** (Regular Physical Education includes exercises such as: Elementary Grades - running, skipping and jumping; Middle grades - competitive or intramural basketball, baseball, touch or flag football, track, tennis, swimming, and soccer, etc.).

\*\*\*I recommend **modified physical activity** (specify degree and reason)(Restricted Physical Education includes less strenuous activities such as: gym assistant, official, and scorekeeper) \_\_\_\_\_

\*\*\* Recommendations for Modified Physical Activity are effective for the current school year only, unless specified below:

COMMENTS: \_\_\_\_\_

FAMILY HISTORY

Give state of health : \_\_\_\_\_  
or cause of death Mother \_\_\_\_\_ Father \_\_\_\_\_ Sisters \_\_\_\_\_ Brothers \_\_\_\_\_

Sickness in the home, please describe: \_\_\_\_\_



Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_ MD

Physician's Printed Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone Number \_\_\_\_\_