PHYSICIAN'S CERTIFICATE
(Chapter 150, Acts 1969, and
Regulation HTO Immunization Requirements
for School Enrollment)
(House Enrolled Act #1352)

ST. PAUL'S LUTHERAN SCHOOL
www.stplmunster.com
(219) 836-6270

Please print and fully complete:

Student's Last Name First Middle

Street Address City State

Birthdate Grade Gender

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		Diptheria Pertusis	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	2			
Whooping Cough		Rubella	1				
		Hepatitis B	1	2	3		
		Varicella (Chicken Pox) (1 grades 1-5 1) (2 age 3-Kindergarten and Grades 6-8	1	2			
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 _____ GENDER _____

Physical and Nutritional Development _____ Mental and Emotional Development _____

SKIN _____ HEAD Hair and Scalp _____

B/P _____ HEIGHT _____ WEIGHT _____

NOSE AND THROAT _____ Palpable Nodes _____ Tonsils CHEST _____ Lungs _____ Heart

ABDOMEN _____ Hernia _____ Inguinal _____ Femoral _____ Umbilical _____ Other

EXTREMITIES _____

ORTHOPEDIC DEFECT _____

Operations (Specify): _____

Serious Accidents: _____

Life threatening allergies or medical conditions: (Specifiy)

_____

PRESCRIPTION MEDICATION : Child takes the following prescription medication on a regular or daily basis (please specify name, dose and reason). Any medication taken during the school day must be sent to school in original packaging along with physician's Prescription Medication instruction form to be effective for the current school year only.

_____

○ I recommend the **regular school program** including 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, volleyball, cheerleading, swimming, and soccer, etc.). (If there is anything about this child's condition that will influence or interfere with regular school life or regular program of physical activity, please note)

COMMENTS _____

○ 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 DO MD

_____

Physician's Printed Name Address Telephone Number

PLEASE COMPLETE OTHER SIDE

1/11