The Wilson School
IMMUNIZATION RECORD AND MEDICAL EXAMINATION
(To be completed and signed by child's physician)

Name of Child (Last, First, M.I.)	Date OF BIRTH (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT OR GUARDIAN		
	NAME	TELEPHONE NO.
	ADDRESS	NAME OF DOCTOR
	ADDRESS	DOCTOR'S TELEPHONE NO.

VACCINE TYPE	DISEASE DATE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS - DTP * *(If DT or Td, indicate in corner box)*							
POLIO ORAL POLIO VACCINE (OPV) *If Salk Vaccine, indicate (IPV) in corner box*							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES					Measles Serology	Date:	Titer:
RUBELLA					Rubella Serology	Date:	Titer:
MUMPS					Mumps Serology	Date:	Titer:
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Date:	Titer:
VARICELLA						Date:	Titer:
Other *(Specify)* MANTOUX TUBERCULIN		—	RESULTS —				

☐ Provisional admission attached–Date Granted:____________ ☐ Medical exemption attached ☐ Religious exemption attached

DISEASE HISTORY	YEAR		YEAR		YEAR	OPERATIONS OR INJURIES	YEAR
ALLERGIES		ASTHMA		OTITIS MEDIA			
DRUG SENSITIVITIES		ASTHMA ACTION PLAN ☐ YES ☐ NO		RHEUMATIC FEVER			
LYME DISEASE		CONVULSIVE DIS.		STREP INFECTIONS			
HEPATITIS		DIABETES		MONONUCLEOSIS			
NEUROMUSC. DIS.		HEART DISEASE		OTHER		CONGENITAL DEFECTS	

MEDICAL EXAMINATION

	Normal	Abnormal Findings
Heart		
Lungs		
Skin		
Lymph Nodes		
Eyes (including vision)		
Ears		
Teeth		
Nose and Throat		
Abdomen		
Nutrition		
Nervous System		
Genito-Urinary		
Musculoskeletal		

Height:	B/P:	Hearing:
Weight:	Speech:	Scoliosis:
Glasses:	Reading/Constantly	Contact Lenses

Current Medication (Name, dosage, etc.) ____________________

RECOMMENDATIONS: ____________________

I certify that I have examined ____________________ Grade ________
within the past six months and find him/her to be in good health and capable of engaging in all of the academic and athletic activities of school, including swimming and a regular sports program. He/She (may/may not) take part in all school activities. If not, please give reasons

____________________, M.D. ____________
Physician's Signature Date