Date:________________

IC 20-34-4-5 STATEMENT OF IMMUNIZATION RULES:
A STUDENT IS NOT PERMITTED TO ATTEND SCHOOL
BEYOND THE FIRST DAY OF SCHOOL
WITHOUT A PHYSICIAN CERTIFICATE OF EXAMINATION FORM

PHYSICIAN CERTIFICATE OF EXAMINATION

(TO BE COMPLETED BY CHILD'S PHYSICIAN UPON EXAM)

NAME:_____________________________________Date of Birth___/___/___

Allergies:____

Chronic Illness:____

Current Medications: (list name, dosage, and time)
1.________________________Dosage____________Time_______________

2.________________________Dosage____________Time_______________

3.________________________Dosage____________Time_______________

Height:___________________ **Weight**______________**B/P**___________

Eyes:______________________ **Ears**_____________________________

Nose:______________________ **Throat**____________________________

Chest:______________________ **Heart**______________**Hernia**___________

Extremities:__________________ **Posture/Scoliosis:**__________________

Other:____

If Indicated:
Lead level:_______________________Sickle Cell:__________________________
Tuberculin Test Results_______________

Is this student physically fit to participate in all physical education programs?___________
If no, please explain:____
____
____
Please list any **chronic illness or condition** that should be considered in planning this child's school day:____
____
____

Please attach signed Immuniaztion History.