St. Charles Borromeo Catholic School
4910 Trier Rd. **Ft. Wayne, IN 46815** **260-484-3392**
schooloffice@stcharlesschoolfw.org **www.stcharlesschoolfw.org**

PHYSICIAN CERTIFICATE OF EXAMINATION
(To be completed by your child's physician)

Name____ Date of Birth____/____/____

Allergies____

Current Medications
1.____________________________________Dosage____________________ Time_____________
2.____________________________________Dosage____________________ Time_____________
3.____________________________________Dosage____________________ Time_____________

Height____________Weight____________ **B/P____________** **Pulse____________**

Eyes _____________________
Ears______________________
Nose______________________
Throat____________________
Chest/Lungs_______________
Heart_____________________
Abdomen__________________
Hernia____________________
Extremities________________
Musculoskeletal____________
Neurological_______________
Skin______________________

Lab Work (If indicated)
Hematocrit ____________
Hemoglobin ____________
Lead Level __________
Sickle Cell ____________
Urinalysis ____________
Other ______________________________

Tuberculin Test (if indicated)
Type of test________________________
Date______________________________
Results____________________________

Is this student physically fit to participate in all physical education programs?

Yes_________ No________ If no, please explain____________________________________

____

Please list any conditions that should be considered in planning this child's school day:
____

____

CONTINUED ON REVERSE

(rev ACNPSA 1/18)

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IMMUNIZATION HISTORY
PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All students must have an immunization record in the school office before the first day of school. This student MAY NOT attend school without a record of having received the required immunizations listed below. The only exception is to have a medical or religious exemption form filed with the school office.

The following immunizations are the minimum requirements by the State of Indiana for

Kindergarten - 4th Grades

DTaP (5)	______	MMR (2)	______
IPV (4)	______	Varicella (2)	______
Hepatitis B (3)	______	Hepatitis A (2)	______

5th Grade

DTaP (5)	______	MMR (2)	______
IPV (4)	______	Varicella (2)	______
Hepatitis B (3)	______		

6th Grade
Previous listed plus an additional Tdap (1),
MCV (1) ______
Hepatitis A (2) ______

7th Grade
Hepatitis A, 2 doses given 6 months apart ______

8th Grade
Previous listed, but Hepatitis A is recommended, not required ______

(These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid.)

____
Printed or Stamped name of the physician completing this form

____
Physician's signature Date