ACADEMY OF THE SACRED HEART

MEDICAL EVALUATION AND IMMUNIZATION RECORD

THE FOLLOWING INFORMATION MUST BE COMPLETED AND SIGNED BY THE STUDENT'S PHYSICIAN OR

STUDENT Name	Grade

PHYSICAL EXAMINATION

To be completed for students entering ASH-FIN, Little Hearts, PK, grades 1, 5, 9, and for all new students.

Date of last examination (must be within the last six months)

Height	**Weight**	**BP**	**Pulse**

Vision	**Hearing**	**Postural**
Without glasses R 20 / ____ L 20 / ____	Right ☐ Pass ☐ Fail	☐ Normal
With glasses R 20 / ____ L 20 / ____	Left ☐ Pass ☐ Fail	☐ Abnormal (Minimal or Slight)
Type of screening	Type of screening	☐ Referral (Moderate or Marked)

Other (Please mark with a ✓ if satisfactory or an X if not satisfactory.)

☐ Appearance	☐ Ears	☐ Heart	☐ Genitalia
☐ Nutrition	☐ Nose	☐ Lungs	
☐ Skin	☐ Throat	☐ Abdomen	
☐ Musculoskeletal	☐ Teeth	☐ Hernia	

Tuberculin Test
Date last given

Type

Result

This student **may participate** in the following
- ☐ Routine school activities
- ☐ Physical education classes
- ☐ Competition sports

Exceptions / special problems / dietary restrictions / recurring abnormalities / prescribed medications / allergies

IMMUNIZATION RECORD

To be completed for students entering ASH-FIN, Little Hearts, PK, K, grades 1-9, and for all new students.

Vaccine	**Month, day, and year dose was given**					
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTaP						
Td						
Tdap						
IPV / OPV						
MMR						
Hib						
Hep A						
Hep B						
Hep B / Hib						
Varicella						
Meningococcal						
Pneumococcal						

Date of next immunization

I certify that this child has received the above noted immunizations and is in compliance with rules set forth by the state of Louisiana, Department of Health and Hospitals, Office of Public Health.

Physician's signature

X ← **SIGNATURE REQUIRED**

Physician's name (Please print.)		Date		
Street address	City	State	Zip code	Phone

Over...