



3380 Fairmount Boulevard
 Cleveland Heights, Ohio 44118
 216-321-7571 PH
 216-321-7568 FX

Child's Name _____ Date of Birth _____

Immunization Information

Please complete with the day/month/year.

DTaP	1. _____	2. _____	3. _____	4. _____	5. _____
Td	1. _____	2. _____	Tdap _____		
Polio	1. _____	2. _____	3. _____	4. _____	5. _____
HIB	1. _____	2. _____	3. _____	4. _____	5. _____
Hepatitis A	1. _____	2. _____			
Hepatitis B	1. _____	2. _____	3. _____		
HPV	1. _____	2. _____	3. _____		
MMR	1. _____	2. _____			
Menactra	1. _____				
Pnuemococcal	1. _____	2. _____	3. _____	4. _____	
Rotovirus	1. _____	2. _____	3. _____		
Varicella	1. _____	2. _____			
Influenza	_____	Other _____			

Examination Date: _____ Normal: _____ Abnormal: _____

Remarks and recommendations concerning abnormal findings: _____

Restrictions: _____

Height _____ Weight _____ BMI _____ Blood Pressure _____ Heart Rate _____

Chronic Health Concerns: Asthma _____ Seizure Disorder _____ ADD/ADHD _____

Diabetes _____ Allergies _____ Other _____

Was the child referred to any specialist? _____

Special tests: (at the physician's discretion)

Urinalysis _____ Hemoglobin _____

Lead _____ Sickle Cell _____

Tuberculin test _____ Results _____

Other _____

Hearing: Type of test _____ Results _____ Comments _____

Vision: Acuity: Right 20/ _____ Left 20/ _____ Strabismus Yes _____

Medications: _____

Physician Name (Please print): _____ Phone: _____

Address: _____ City/State/Zip _____

I certify that this child is in suitable condition for enrollment in school.

Physician Signature: _____ Date: _____