Lutheran South Unity School
5401 S. Calhoun Street
Fort Wayne, IN 46807
260-744-0459
Krista Nagy, Principal
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Allen County Non-Public School Association

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

(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

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 requirement by the State of Indiana for

Kindergarten, 1st and 2nd Grades

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

3rd-5th Grades

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

6th-8th Grades

Previous listed plus an additional Tdap (1) and MCV (1)

(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**

(rev ACNPSA 1/16)