

# MEDICAL EVALUATION AND IMMUNIZATION RECORD 10-11

CHECK IF THIS STUDENT IS NEW TO COUNTRY DAY

**METAIRIE PARK COUNTRY DAY SCHOOL**  
**STUDENTS MAY NOT ATTEND SCHOOL WITHOUT THIS FORM ON FILE.**  
**DUE JULY 15<sup>TH</sup>**

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_  
LAST FIRST MIDDLE

<b>FULL EXAM 7TH THROUGH 12TH GRADE</b>	<b>LIMITED EXAM PRE-K THROUGH 6<sup>TH</sup> GRADE</b>	<b>HEIGHT:                      WEIGHT:                      BLOOD PRESSURE:                      /</b>			
		<b>SYSTEM</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>COMMENTS</b>
		HEART			
		LUNG			
		OTHER			
		ABDOMINAL			
		GENITALIA			
		NECK			
		SHOULDER			
		ELBOW			
		WRIST			
		HAND			
		BACK			
		KNEE			
		ANKLE			
		FOOT			
		EYE			

CLEARANCE: (INCLUDES NORMAL SCHOOL ACTIVITIES INCLUDING ATHLETIC ACTIVITIES IN GRADES 7-12)

\_\_\_ A. **FULL** – CLEARED FOR ALL SCHOOL ACTIVITIES (INCLUDING ATHLETIC ACTIVITIES).

\_\_\_ B. **NOT CLEARED** – FOR THE FOLLOWING SPORTS \_\_\_\_\_ COLLISION \_\_\_\_\_ CONTACT \_\_\_\_\_ NONCONTACT

SIGNIFICANT HISTORY/CHRONIC ILLNESS: \_\_\_\_\_

RECOMMENDATIONS: \_\_\_\_\_

PRINT NAME OF MD: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ AFTER HOURS: \_\_\_\_\_ SIGNATURE OF PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

## IMMUNIZATION RECORD

VACCINE	DATE DOSE 1	DATE DOSE 2	DATE DOSE 3	DATE DOSE 4 OR BOOSTER	DATE DOSE 5 OR BOOSTER
DPT/DT/DTAP/TD					
OPV/IPV					
MMR					
Hib					
Hepatitis B					
Hepatitis A					
MCV 4 MENINGOCOCCAL					
Varicella/Chicken Pox					
PCV 7 PNEUMOCOCCAL					
HPV					
OTHER					

