DANBURY LOCAL SCHOOLS

Physical/Immunization

_____ _____

Child's Name (Print or Type) *Date of Birth*

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in a school setting.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:_____

_____

List any physical, developmental or behavioral issues or health conditions for this child (including allergies, daily medication, dietary restrictions):_____

_____

_____

Recommended Immunizations (enter mm/dd/yyyy)					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
*Diptheria, Tetanus, Pertussis (DTaP)					
*Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
*Measles, Mumps, Rubella (MMR)					
*Inactivated Polio					
*Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.
*Required for Public School Enrollment

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐No Date: _____ Hearing: ☐ Yes ☐ No Date: _____
Dental: ☐ Yes ☐No Date: _____ Lead: ☐ Yes ☐ No Date: _____
BMI: ☐ Yes ☐ No Date: _____ Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

_____

Name of Physician/Physician's Assistant/Advanced Practice Nurse Telephone Number

_____

Street Address

_____

City, State, Zip Code

IT IS REQUIRED THAT THIS EXAM BE GIVEN NO MORE THAN 12 MONTHS PRIOR TO THE DATE OF ADMISSION