Shepherd of the Hills Lutheran School & Child Care

PHYSICIAN'S STATEMENT OF GOOD HEALTH & IMMUNIZATION RECORD | 2016 – 2017

This form MUST be completed by a physician and returned no later than *08/01/2016* for new enrollees or from 12 months from a returning student's previous record submittal. *Please submit to TADS.*

Parent/Guardian Please Complete

Child's Name: _____ Grade/Age Level Entering: _____

Child's Birth date: _____ Doctor's Name: _____

Doctor's Phone #: _____ Doctor's Address: _____

Preferred Hospital: _____

I hereby authorize agents of SHLS to transport my child and secure emergency medical care for my child in the event I can not be reached:

_____ _____

Signature of Parent/Guardian **Date**

Physician's Statement of Good Health

(Doctor should complete below)

I have examined the above named child on this date: _____ and find that he/she is free of infection and contagious disease and is physically able to participate in the school and extra-curricular activities and the athletic program. _____No Exceptions **OR** except as follows

List: _____

_____ _____

Signature of Physician **Date**

VISION | Distance Acuity Screen: *(State required exam for all new and returning students, grades PK-8th.)*

Date: _____

Pass: ___Yes ___No With Correction? __Yes __No

Right Eye: 20/

Left Eye: 20/

Chart Used: __Letter __"E" __ H:O:T:V __ Machine __ Other

HEARING Screening at 25 db: *(State required exam for all new and returning students, grades PK-8th.)*

Date: _____

Frequency: 25db	Right	Left	Results
1000Hz			__Pass __Fail
2000 Hz			__Pass __ Fail
4000 Hz			__ Pass __ Fail

******SCOLIOSIS SCREENING MUST BE DONE FOR ALL STUDENTS ENTERING 6TH GRADE.***

____ Free of Scoliosis ___Should be Re-screened Date for Re-screen _____

____ Under Treatment Type: _____

OVER →

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For new students, please complete the Immunization Information below. A copy may be attached or the record may be transcribed. Please include all dates as M/D/Y.

For returning students, please note any new immunizations below. Please include all dates as M/D/Y.

☐ Check if No New Immunizations were given.

Immunization History For: _____

Health Professional's Signature: _____

Vaccine Administered	**Dose 1 Date**	**Dose 2 Date**	**Dose 3 Date**	**Dose 4 Date**	**Dose 5/ Booster Date**
DTP/DTaP					
Td Booster					
Opv/IPV(polio)					
MMR					
HiB					
Hepatitis B					
Hepatitis A			XXXXXXX	XXXXXXXXX	XXXXXXXX
Varicella or Date of Disease					
Pneumoccal Conjugate/PCV					

Tuberculosis Screening (If applicable): Date: _____ Result: _____

Other Vaccines Received:

Vaccine Name	**Dose #**	**Date**