PHYSICIAN REPORT AND HEALTH RECORD

Immanuel Lutheran School
4650 Sunview Drive
Loveland, CO 80538
970-667-7606 / Fax: 970-624-3422

IMPORTANT: **All preschool students and students/siblings signed up for the childcare must have a current physical on file each year. All kindergarten, 5th graders, new students and all 5th – 8th grade students in sports must have a current physical on file.**

Child's Name_____ **Sex** _____ **Birth date**_____

Address_____ **Telephone Number (____)**_____
Street **City** **Zip**

Parent's Name _____

MEDICAL HISTORY - to be completed by parent

Check illnesses your child has had:

Illness	**Year**	**Illness**	**Year**
Chicken pox		Rheumatic fever	
Scarlet fever		Strep throat	
Measles		Mumps	
German measles		Ear infection	

Check the following conditions your child has acquired or experienced:

Diabetes _____
Epilepsy _____
Heart diseases _____
Allergies (list) _____
_____
_____
Asthma (list) _____

Injuries/Accidents _____
_____
Permanent disability _____
_____
Surgery _____
_____
_____

Other Health Concerns/Notes to Teacher:

_____
_____
_____

_____ _____
Parent/Guardian Signature **Date**

PHYSICIAN EXAMINATION

Code: 0-No Pathology; **1**-Slight Pathology**; 2**-Remedial Defect**; 3**-Marked Pathology

_____ Posture	_____ Thorax	_____ Genitalia Lab Results:	
_____ Eyes	_____ Thyroid	_____ Feet	_____ Urinalysis
_____ Ears	_____ Lungs	_____ Nervous System	_____ Blood Test
_____ Nose	_____ Heart	_____ Hearing (if tested)	_____ EB
_____ Mouth	_____ Pulse	_____ Vision	_____ Sed. Rate
_____ Skin	_____ Abdomen	_____ Other	
_____ Throat	_____ Hernia	_____ Height	
_____ Lymph Nodes	_____ Weight		

Summary of Findings and Recommendations:
Over-all health (circle): Excellent Good Fair Poor

Medication: (if any)_____ If need to take at school, please fill out medication form.

Sports Clearance: (5th - 8th Grade)

_____, may participate in the sports listed below unless circled.
Student Name

Baseball Basketball Cross-country Football Golf Gymnastics Swimming Tennis Track Volleyball Wrestling Cheerleading

_____ _____
Physician's Signature **Date**

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name_____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Measles	Measles						
Mumps	Mumps						
Rubella	Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date		Lab Verification Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

Name_____ **Date of Birth** _____

Parent/Guardian _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption *to the following vaccine(s):*

La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption *to the following vaccine(s):*

Exención por motivos religiosos *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption *to the following vaccine(s):*

Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)