DIOCESEF CHARLOTTE
STUDENT HEALTH RECORD

SCHOOL GRADE

NAME(LAST) (FIRST) (MIDDLE) BIRTH DATE SEX

FATHER AND MOTHER (MAIDEN NAME) OR GUARDIAN

ADDRESS CITY/STATE ZIP

RECORD OF IMMUNIZATION (Enter date of EACH dose - Mo/Day/Year)

DTaP	**POLIO**	**MEASLES**	**Hib**	**HEPATITIS B**	**HPV**
#1	#1	#1	#1	#1	#1
#2	#2	#2	#2	#2	#2
#3	#3	**MUMPS**	#3	#3	#3
#4	#4	#1	#4	**HEPATITIS A**	**MENINGITIS**
#5	**MMR**	#2	**VARICELLA**	#1	#1
Tdap	#1	**RUBELLA**	#1	#2	
#1	#2	#1	#2		
#2					

STATE LAW REQUIRES MINIMUM DOSES FOR EACH VACCINE (SEE REVERSE)
NOTE: Exemptions from NC State Immunization Law require that a statement must be on file in student's permanent record. Exemptions must meet requirements of the law. Medical_______

HEIGHT__________ WEIGHT__________ BP__________LAB REPORT__________

VISUAL ACUITY (R)__________ (L)__________ W/O GLASSES/CONTACTS

HEARING PASS__________ FAIL__________

PHYSICAL EXAM	**NORMAL**	**ABNORMAL**	**PHYSICIAN'S COMMENTS**
NUTRITION			
SKIN AND SCALP			
ENT			
TEETH			
EYES			
HEART			
LUNGS			
ABDOMEN			
ORTHOPEDIC			
NEURO			

CHECK BOX	**PRESENT**	**ABSENT**	**PHYSICIAN'S COMMENTS**
EMOTIONAL/MENTAL BEHAVIOR PROBLEM			
PHYSICAL HANDICAP-LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER HANDICAP/DISABILITY:			
SEIZURES			
ALLERGIES			
ON MEDICATION (SPECIFY)			
FOLLOW-UP RECOMMENDED			

☐ **Cleared - I certify that I have examined the above named student and that such exam reveals no condition that would prevent this student from participating in interscholastic sports or physical education classes.**

☐ **Not cleared. If student not qualified, list reasons.** ____

DATE of EXAM__________ PHYSICIAN'S SIGNATURE____

Physician's Address____

Revised 10/03