ESU #8 SCHOOL HEALTH PHYSICAL FORM

Name_____ **School**_____

Address_____ **Date of Birth**_____

Parent or Guardian_____ **Phone (home)**_____ **(cell)**_____

Immunizations	Month/Day/Year	Given By:
DTaP/DTP/TD (Diphtheria-Tetaus-Pertussis)	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
Polio (IPV, OPV)	1.	
	2.	
	3.	
	4.	
	5.	
MMR (Measles-Mumps-Rubella)	1.	
	2.	
Hepatitis B	1.	
	2.	
	3.	
Varicella	1.	
	2.	
HIB	1.	
	2.	
	3.	
Other		

Medical History	Yes	No	Comments:
Allergies			
Asthma			
Diabetes			
Glasses/Vision Difficulties			
Head Injury			
Hearing Loss or Difficulties			
Heart Problems			
Orthopedic Problems			
Seizures			
Surgery			
Current Medications / Dose / Reason:			

I give my consent to share this information with school personnel. *Parent Signature*_____ *Date*_____