CONCORDIA LUTHERAN SCHOOL

PRESCHOOL • ELEMENTARY SCHOOL • MIDDLE SCHOOL

A Ministry of Concordia Lutheran Church

RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

Must be completed by child's physician

Name_____ Date of Birth____/____/____

Allergies_____

Current Medications: (list name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

3._____Dosage_____Time_____

Height_____ **Weight**_____ **B/P**_____ **Pulse** _____

Eyes _____
Ears _____
Nose _____
Throat _____
Chest/Lungs _____
Heart _____
Abdomen _____
Hernia _____
Extremities _____
Musculoskeletal _____
Neurological _____
Skin_____

Lab Work *(if indicated)*
Hematocrit _____
Hemoglobin _____
Lead Level _____
Sickle Cell _____
Urinalysis _____
Other_____

Tuberculin Test *(if indicated)*
Type of test _____
Date _____
Results _____

Is this student physically fit to participate in all physical education programs?

Yes_____ No_____ If no, please explain_____

Please list any conditions that should be considered in planning this child's school day:

_____

Student Name _____ **Grade** _____

ENGAGING HEARTS AND MINDS

4245 LAKE AVENUE ▪ FORT WAYNE, IN ▪ 46815

PHONE: (260) 426-9922 x200 ▪ FAX: (260) 422-6980 ▪ E-MAIL: school@clscubs.org

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IMMUNIZATION HISTORY

PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All students must have an immunization record in the school office *before the first day of school*. This student MAY NOT attend school without a record of having received the required immunizations listed below or unless a medical OR religious exemption form has been filed with the school office.

Required vaccinations are as follows:

Kindergarten –5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

6th and 8th Grades

Previous listed plus additional Tdap (1) and MCV4 (1)

********These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid in the State of Indiana .********

_____

Printed/Stamped Name of Physician Completing this Form _____

_____ _____

Physician's Signature Date

(rev ACNPSA 1/21)

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