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Immunization & Medical Fitness Form

This form will be used to determine the fitness of the student for participation in athletics

Student's Name: First	Last(surname)	**Grade**	**Sex**	**ID#**

Parent/Guardian		**Emergency contact number to notify if parents are unavailable**	**Blood Group**
Phone: Home:	**Work**		

Immunization

VACCINE/DOSE	1 (dd/mm/yy)	2 (dd/mm/yy)	3 (dd/mm/yy)	4 (dd/mm/yy)	5 (dd/mm/yy)	6 (dd/mm/yy)
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenza type b (Hib)					Last TB Test	
Hepatitis B					Date	Result
Varicella (Chickenpox)						
Combined Measles, Mumps & rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Hepatitis A, BCG						
Other (Meningococcal, etc. Specify)						

State reason if a vaccine is contraindicated:_____

_____

_____

Medical Fitness

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

Have you ever had, or do you currently have, any of the following conditions?

1.	Asthma	Y / N	13.	Autism spectrum disorders	Y / N
2.	Diabetes	Y / N	14.	Low or high blood pressure	Y/ N
3.	Blood disorders	Y / N	15.	Low or high blood pressure	Y / N
4.	Allergy to pollen, latex, bee Stings or foods?	Y / N	16.	Hemophilia, Sickle cell, other?	Y / N
5.	Allergy to medications?	Y / N	17.	Dizziness or passing out during or after exercise without known cause?	Y / N
6.	Concussion or head injury	Y / N	18.	Vision problems	Y / N
7.	Seizure	Y / N	19.	Bone/joint problems / Dislocated joints	Y / N
8.	Frequent or severe headaches	Y / N	20.	Upper or lower back pain	Y / N
9.	Heart problems, murmur	Y / N	21.	Coughing, wheezing or shortness of breath in weather changes or normal condition?	Y / N
10.	Convulsive disorder	Y / N	22.	Surgery	Y / N

Explain (type of problem, treatment date, current treatment, etc.) all "yes" answers here (include relevant dates):

_____

_____

_____

_____

_____

Are there limitations on participation in athletics? □ YES □ NO
If yes, please explain

List all medications here:

Medication Name	Purpose	Dosage	Frequency

Parent/Guardian Signature

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature, Parent/Guardian Date of Signature: