**2011-12**

**McGehee Nursing Office**
Maria Meyer, B.S.N., R.N.
2343 Prytania Street, New Orleans, LA 70130
Phone: 504-274-4941
DUE JULY 1

❑ Check if this student is new to McGehee

**STUDENTS MAY NOT ATTEND SCHOOL WITHOUT THIS FORM ON FILE.**

# MEDICAL EVALUATION AND IMMUNIZATION RECORD

**(To be completed by physician)**

STUDENT'S NAME: _____ GRADE: _____
LAST FIRST MIDDLE

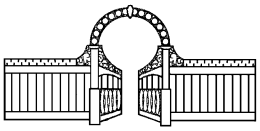
PREFERRED NAME: _____ Date of Birth_____

**IMMUNIZATION RECORD:** Minimum grade school-entry requirements are:

- **4 DPT** (provided the last dose was administered on or after their 4th birthday, if not, a 5th dose is required)
- **3 Polio** (provided the last dose was administered on or after their 4th birthday, if not, a 4th dose is required)
- **2 MMR** (one after the 1st birthday and one before entering school)
- **3 HBV** (Hepatitis B vaccine)
- **2 Varicella vaccine** (Chicken pox)
- **Hib**
- **1 Meningococcal Vaccine (MCV-4) (6-12th grade)**

**COMPLETE IMMUNIZATION RECORD REQUIRED.**

| VACCINE | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| DTaP | | | | | | |
| DTaP/Hep B/IPV | | | | | | |
| Tdap | | | | | | |
| Td (Adult) | | | | | | |
| IPV | | | | | | |
| Hib-unspecified | | | | | | |
| Hep B Ped/Adol - Preserv Free | | | | | | |
| Hepatitis B (Adult) | | | | | | |
| MMR | | | | | | |
| Varicella | | | | | | |
| MMR/Varicella | | | | | | |
| Hep B/Hib | | | | | | |
| Pneumococcal (PCV7) | | | | | | |
| Hep A 2 dose - Ped/Adol | | | | | | |
| Hep A 2 dose - Adult | | | | | | |
| Influenza split, 6-35 mos. presv free | | | | | | |
| Influenz split, 36 mos. and older | | | | | | |
| Influenza split, 36+ mos. presv free | | | | | | |
| Meningococcal Conjugate (MCV4) | | | | | | |
| Rotavirus, pentavalent | | | | | | |
| HPV, quadrivalent | | | | | | |
| Other | | | | | | |



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**(To be completed by physician)**

| | | | | | |
|---|---|---|---|---|---|
| | **LIMITED EXAM** | **HEIGHT** | **WEIGHT** | **BLOOD PRESSURE** | **/** |
| | | **SYSTEM** | **NORMAL** | **ABNORMAL** | |
| | **LITTLE GATE THRU 6TH** | HEART | | | |
| | | LUNG | | | |
| | | OTHER | | | |
| **FULL EXAM** | | ABDOMINAL | | | |
| | | GENITALIA | | | |
| | | NECK | | | |
| | | SHOULDER | | | |
| **7TH THRU 12TH** | | ELBOW | | | |
| | | WRIST | | | |
| | | HAND | | | |
| | | BACK | | | |
| | | KNEE | | | |
| | | ANKLE | | | |
| | | FOOT | | | |
| | | EYE RIGHT 20 / | LEFT 20 / | CORRECTED YES / NO | |

**CLEARANCE:** *(INCLUDED NORMAL SCHOOL ACTIVITIES **INCLUDING ATHLETIC ACTIVITIES GRADES 6-12**)*

_____ A. **FULLY CLEARED** FOR ALL SCHOOL ACTIVITIES ***(Including Athletic Activities)***

_____ B. **NOT CLEARED** FOR THE FOLLOWING SPORTS ____ COLLISION ____ CONTACT ____ NONCONTACT

LIST THE SPORTS FOR WHICH THIS CHILD IS **NOT** CLEARED. _____

SIGNIFICANT HISTORY/CHRONIC ILLNESSES: _____

_____

RECOMMENDATIONS: _____

_____

PRINT NAME OF MD: _____

ADDRESS: _____

PHONE: _____ AFTER HOURS: _____

SIGNATURE OF PHYSICIAN: _____DATE: _____