

**DIOCESE OF 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)**

VACCINE	#1	#2	#3	#4	#5
DTP/DTaP					
Tdap					
POLIO					
Hib					
MMR			HEPATITIS B	SERIES	
MEASLES			#1	#2	#3
MUMPS			VARICELLA	#1	#2
RUBELLA			MCV	#1	#2
PCV					

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 \_\_\_\_\_