

**DIOCESE OF CHARLOTTE  
STUDENT HEALTH RECORD**

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MIDDLE) \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_

MOTHER (MAIDEN NAME) AND FATHER OR GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

<b>RECORD OF IMMUNIZATION</b> (Enter date of EACH dose – mm/dd/yy)					
VACCINE	#1	#2	#3	#4	#5
DTAP/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

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.

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 participation in interscholastic sports or physical education classes.
- Not Cleared – If student not qualified, list reason: \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_  
 PHYSICIAN'S ADDRESS \_\_\_\_\_