

York Elementary School

Student Immunization Record

Maine State Law requires all students in kindergarten through the 12th grade be protected against polio, diphtheria, tetanus, pertussis, measles, rubella, mumps and chicken pox. These requirements can only be waived if properly signed medical, religious or personal objection is filed with the school.* According to state law, students who do not have a record of immunization at the time of registration are allowed 90 days to present one. Students who have not presented evidence of immunization after 90 days will not be able to attend school until the requirements are met.

Student's Name _____ Birth Date _____ Grade _____

Parent/Guardian's Name _____

Immunization History

List the month, day and year this student received each of the following immunizations. DO NOT USE A () or (X). If you do not have an immunization record for this student at home, contact your doctor/health care provider to obtain the dates.

TYPE OF VACCINE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
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DPT/DT/TD _____

POLIO _____

MEASLES _____

RUBELLA _____

MUMPS _____

CHICKEN POX _____

OTHER _____

REQUIRED IMMUNIZATIONS

The following represents MINIMAL requirements only. Parents are urged to consult with their physician/health care provider regarding additional doses and types of vaccine that are recommended.

Diphtheria, tetanus, pertussis (DPT): 5 doses required unless dose #4 is given after age 4.

Measles, Mumps, Rubella (MMR): 2 doses needed

Polio: 4 doses required (3 doses required if last dose is given after age 4).

Varicella (chicken pox) vaccine: 1 time vaccination

***State Statute Reverence - Title 20 MRSA, Sections 1191-1196-1981**

Does this student meet the minimum immunization requirements?

YES - Sign below and return this form to the school.

NO- If no, check the appropriate box below, sign and return this form to school. Please note, INCOMPLETELY IMMUNIZED STUDENTS MUST BE EXCLUDED FROM SCHOOL IN AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

Although my child has not received all of the required doses, he/she has received at least the first dose of the vaccine required. I understand that the remaining required immunizations must be completed on schedule and that all must be completed within one year. I also agree to report in writing the type and the date of the required immunizations as they are given.

EXEMPTIONS

For health reasons this student should not receive the following immunizations:

Physician's signature

For religious, moral, philosophical or personal objection this student is not, immunized with the following required vaccines:_____

Parent/Guardian is asked to provide a written explanation in the space that follows:

This form is complete and accurate to the best of my knowledge.

Signature of Parent/Guardian

Date

York School Department

Student Physical Examination Record

TO PARENTS: A health examination by your family physician is important to your child's welfare and to the school in adapting its program to individual needs. Please complete this form before your child enters school. Ask your physician to complete the physical examination portion.

Student's Name

Birth Date

Address

Telephone Number

Parent or Guardian

Business Telephone

Name of person to be
called in Emergency

Address

Telephone

Dentist

Address

Telephone

Ophthalmologist/
Optometrist

Address

Telephone

Student's General Health: _____ Illnesses/Diseases _____

Behavior _____ Accidents/Operations _____

Family's Health Status:

Father _____ Brother(s) _____

Mother _____ Sister(s) _____

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

PLEASE ANSWER ALL QUESTIONS

1. Is there any defect of vision, hearing or speech for which the school could compensate by proper seating or other actions? Yes () No ()

If yes, please describe:

2. Is this student subject to any condition which limits:

Classroom Activity?

Yes ()

No ()

Physical Education?

Yes ()

No ()

Competitive Athletics?

Yes ()

No ()

If yes, please describe:

3. Is this students subject to any condition which may result in a classroom emergency E.G.

Epilepsy, Fainting, Diabetes, etc.?

Yes ()

No ()

If Yes, Please describe:

4. Is there any emotional, mental or behavioral condition for which this student should remain under periodic professional services. Yes () No ()

If yes, please describe:

5. Is there any physical condition for which this student should remain under medical care other than periodic evaluations?

Yes ()

No ()

If yes, please describe:

6. Have you prescribed any medications for this student which must be taken on a regular basis?

Yes ()

No ()

If yes, please describe:

7. Does this student have an allergy/asthmatic condition requiring specific treatment?

Yes ()

No ()

If yes, please describe:

8. According to your records, are immunizations up to date?

Yes ()

No ()

If no, please identify deficiencies and plans to remedy:

9. Impressions, recommendations or comments from today's evaluation:

Name of Physician (Please print)

Address

Physician's signature

Date