

# Adelphi Academy

8515 Ridge Boulevard  
 Brooklyn, New York 11209  
 Phone (718) 238-3308 ~ Fax (718) 238-2894  
 adelphiacademy.org

## Student Medical and Immunization Records Form 2009-2010

Students Name: \_\_\_\_\_ D.O.B: \_\_\_ / \_\_\_ / \_\_\_

Home Address: \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Parent's Name: \_\_\_\_\_ / \_\_\_\_\_ Grade: \_\_\_\_\_

### IMMUNIZATION HISTORY

Vaccine Dates
DPT #1:
DPT #2:
DPT #3:
DPT #4:
DPT #5:
TD:
MMR #1:
MMR #2:
Polio #1:
Polio #2:
Polio #3:
Polio #4:
Hib #1:
Hib #2:
Hib #3:
Hib #4:
Hepatitis B Vaccine:
HBV #1:
HBV #2:
HBV #3:
Varicella Vaccine:

<b>Other Immunizations:</b>	
PPD (TB):	Read:
Negative _____	
Positive _____ mm	

### PAST MEDICAL HISTORY

Measles-	/	/
Asthma-	/	/
Seizures-	/	/
Mumps-	/	/
Rheumatic Fever-	/	/
Chicken Pox-	/	/
Whooping Cough-	/	/
Diabetes-	/	/
Pneumonia-	/	/
Physical Disabilities-	/	/

### DEVELOPMENT ASSESSMENT

HCT or HGB Screening-
Lead Poisoning Screening-
Dental Screening-
Nutritional Screening-
Urinalysis-
Speech-
Allergies and Reactions-
Medications-
Scoliosis Screening-
Hospitalizations-

### PHYSICAL EXAM *Date:* \_\_\_\_\_

Weight-
Height-
Blood Pressure-
Hearing Evaluation-
Vision Assessment-
<u>General Health-</u>

Based on the review of the medical history and the results of this physical examination, this student may participate in the following sports:

DRAW A LINE THROUGH ANY SPORTS TO BE OMITTED:

CONTACT

Baseball  
Basketball  
Soccer  
Lacrosse  
Softball  
Football

ENDURANCE

Gymnastics  
Swimming  
Track & Field  
Cross-Country  
Tennis  
Volleyball

OTHER

Bowling  
Golf  
Field Events  
Cheerleading  
Kickline/Dance  
Karate

Date of last Tetanus Booster: \_\_\_\_\_

Clinician's Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*MEDICAL ALERT SECTION\***

Pertinent Past Medical History: \_\_\_\_\_

Medications (If Any): \_\_\_\_\_

Allergies of Any Kind (Food, etc.): \_\_\_\_\_

All information documented on this sheet has been validated by:

\_\_\_\_\_  
Name (Printed) of Medical Doctor/  
Licensed Health Care Practitioner

\_\_\_\_\_  
Signature of Medical Doctor/  
Licensed Health Care Practitioner

\_\_\_\_\_  
Agency/Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date