SCHOOL DISTRICT QF PHILADELPHIA
CENTRAL HIGH SCHOOL
SCHOOL HEALTH SERVICES IMMUNIZATION RECORD

THE PHYSICAL EXAMINATION MUST HAVE TAKEN PLACE NO EARLIER THAN SEPTEMBER OF 2017. A student cannot be admitted with an incomplete immunization record per the State of Pennsylvania and may be sent home the first day of school by the school nurse.
IF YOUR DOCTOR CANNOT FILL OUT THE PHYSICAL EXAMINATION BY APRIL 14TH IT SHOULD BE RETURNED IN AUGUST DURING FRESHMAN ORIENTATION WEEK.

_____ _____ _____
Name Current School M.I.

_____ _____ _____
Date of Birth ID Number Room/Book

IMMUNIZATIONS REQUIRED:
VACCINE - ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN

	DOSES			
Diptheria & Tetanus (DTap, DTP, Td or DT) *	1. __/__/____	2. __/__/____	3. __/__/____	
	4. __/__/____	5. __/__/____		
Tdap:	1. __/__/____			
Polio, (OPV or IPV) *	1. __/__/____	2. __/__/____	3. __/__/____	
Hepatitis B	1. __/__/____	2. __/__/____	3. __/__/____	
Meningococcal	1. __/__/____	2. __/__/____		
Measles** - Mumps** – Rubella(MMR)	1. __/__/____	2. __/__/____	or	
Measles Serology: Date_____ Titer_____or Rubella Serology: Date_____				
Titer_____or Mumps disease diagnosed by a physician: Date: _____				
Varicella***	1. __/__/____	2. __/__/____		
(CHICKENPOX) or date of past disease verified by doctor's note_____				

Additional Immunization Rec'd. Type _____ Date _____
Type _____ Date _____

*One dose must be on or after the fourth (4th) birthday.
**First dose must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose.
*****Children in all grades K-12 will need 2 doses of varicella vaccine on/after 1st birthday, or documented history of disease for the 2017-2018 school year.**

***NOTE: If your child has a blood test (titer) showing immunity to measles, or varicella, or if your child has had mumps disease diagnosed by a doctor, please attach a statement from your doctor.**

This child cannot be immunized for:

_____ Religious Reasons (Please explain, in writing.)

_____ Medical Reasons (A note from your doctor must be attached.)

_____ _____ _____
Date Signed Doctor's Signature Doctor's Phone Number

_____ _____ _____
Date Signed Parent or Guardian Signature Home Phone