

MUST BE RETURNED TO THE SCHOOL OFFICE BEFORE SEPTEMBER 1ST

Our Savior's Lutheran School
63 Mountain View Ave. - Albany, New York 12205
(518) 459-2273 - FAX (518) 459-1330

Pupil's name _____

Grade _____ M ___ F ___ Birth Date _____

To the physician: This child will be attending Our Savior's Lutheran School next fall and we are recommending that parents have him or her examined by the child's doctor. Will you kindly complete the following form, sign it and give it to the parent to return to the child's school as soon as possible.

IMMUNIZATIONS and COMPLETE DATES

Polio	1	2	3	4	
DtaP, DTP	1	2	3		
MMR	1	2			
Hep B	1	2	3		
Hib	1	2	3	3 doses if given before 15 months	
Varicella	1				

Physical Examination

Significant illness in the past or injury (including allergies, convulsions, etc.):

Scoliosis Check _____ Height _____ Weight _____ Blood Pressure _____

Eyes _____ R20/_____ L20/_____ Ears _____ Hearing _____

Nose and Throat _____ Mouth and Teeth _____

Respiratory _____ Cardiovascular _____

Abdominal organs _____ Hernia _____

Neurological _____ Genito-Urinary _____

Musculoskeletal _____ Skin _____

Speech _____ Behavior _____

Remarks: (include any modifications of school program recommended because of medical conditions):

Physician's Signature _____ **Date:** _____

