PROVIDING CHILDREN WITH EDUCATION FOR ETERNITY

Medical Examination

For students of Pennsylvania Conference of Seventh-day Adventists Office of Education

Student's Name: _____ Age: _____

Address: _____
Street City State Zip

Name of School: Mountain View Christian School Date of Birth: _____

Name of Doctor: _____ Grade: _____

Date of Examination: _____

IMMUNIZATION STATUS

Give the date of each immunization or date of blood test to prove immunity.

	First Dose	Second Dose	Third Dose	Fourth Dose	Additional Doses needed at this time?
❑DtaP ❑DTP ❑DT					❑Yes ❑No
Td				Three doses required for pupils 7 or older	❑Yes ❑No
Polio				3 doses for pupils less than 18	❑Yes ❑No
Measles			2 doses of live virus vaccine by first birthday	Proof of immunity by positive blood test acceptable	❑Yes ❑No
Rubella		1 dose of live virus vaccine	Vaccine must have been given on or after first birthday	Proof of immunity by positive blood test acceptable	❑Yes ❑No
Mumps		1 dose of live virus vaccine	Vaccine must have been given on or after first birthday	Proof of immunity by positive blood test acceptable	❑Yes ❑No
Haemophilus influenza type B		1 dose of live virus vaccine	Vaccine must have been given on or after first birthday	Proof of immunity by positive blood test acceptable	❑Yes ❑No
Hepatitis B				Three doses required for pupils 5 or older	❑Yes ❑No
Chickenpox		1 dose of live virus vaccine	Vaccine must have been given on or after first birthday	Proof of immunity by positive blood test acceptable	❑Yes ❑No

Has the student received a smallpox immunization? ❑ NO ❑YES If Yes, date:_____

Are there medical reasons for this child to be exempted from any of the above immunizations?
❑ NO ❑YES If Yes, explain:_____

_____

P: 1.570.327.9238 F: 1.570.327.1665 A: 305 Fleming St. South Williamsport, PA 17702 W: www.MVChristianSchool.com

Results of Tuberculin Test ❑ NO ❑YES Type of Test:_____

Explain any Positive results: _____

_____

_____

1. Is child subject to conditions that may cause classroom emergencies such as diabetes, fainting, allergies, asthma, etc? ❑ NO ❑YES

Explain: _____

2. Have there been any illnesses, accidents, operations, or defects that limit this child's participation in classroom activities or PE? ❑ NO ❑YES

Explain: _____

3. Are there any vision or hearing defects for which the school could help compensate by seating or other action? ❑ NO ❑YES

Explain: _____

4. Are there any other defects for which the school could help by seating, or other action? ❑ NO ❑YES

Explain: _____

5. Is there evident need for dental care? ❑ NO ❑YES

Explain: _____

6. Is there any reason for which this child should remain under a physician's periodic observation? ❑ NO ❑YES

Explain: _____

7. Physician's recommendations to school:_____

_____

_____

_____ _____

Signature of Physician **Date**

Name of Doctor's Office or Clinic: _____

Office Address: _____

Street City State Zip

Phone Number: _____

P: 1.570.327.9238 F: 1.570.327.1665 A: 305 Fleming St. South Williamsport, PA 17702 W: www.MVChristianSchool.com