



## Immunization & Medical Fitness Form

*This form will be used to determine the fitness of the student for participation in athletics*

|                              |             |               |  |            |                    |
|------------------------------|-------------|---------------|--|------------|--------------------|
| <b>Student's Name:</b> First |             | Last(surname) | <b>Grade</b>   | <b>Sex</b> | <b>ID#</b>         |
| <b>Parent/Guardian</b>       |             |               | <b>Emergency contact number to notify if parents are unavailable</b> |            | <b>Blood Group</b> |
| <b>Phone: Home:</b>          | <b>Work</b> |               |  |            |                    |

| Immunization                                    |                 |                 |                 |                 |                 |                 |
|---|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| VACCINE/DOSE                                    | 1<br>(dd/mm/yy) | 2<br>(dd/mm/yy) | 3<br>(dd/mm/yy) | 4<br>(dd/mm/yy) | 5<br>(dd/mm/yy) | 6<br>(dd/mm/yy) |
| Diphtheria, Tetanus and Pertussis (DTP or DTaP) |                 |                 |                 |                 |                 |                 |
| Diphtheria and Tetanus (Pediatric DT or Td)     |                 |                 |                 |                 |                 |                 |
| Inactivated Polio (IPV)                         |                 |                 |                 |                 |                 |                 |
| Oral Polio (OPV)                                |                 |                 |                 |                 |                 |                 |
| Haemophilus influenza type b (Hib)              |                 |                 |                 |                 | Last TB Test    |                 |
| Hepatitis B                                     |                 |                 |                 |                 | Date            | Result          |
| Varicella (Chickenpox)                          |                 |                 |                 |                 |                 |                 |
| Combined Measles, Mumps & rubella (MMR)         |                 |                 |                 |                 |                 |                 |
| Measles (Rubeola)                               |                 |                 |                 |                 |                 |                 |
| Rubella (3-day measles)                         |                 |                 |                 |                 |                 |                 |
| Mumps   |                 |                 |                 |                 |                 |                 |
| Hepatitis A, BCG*                               |                 |                 |                 |                 |                 |                 |
| Other (Meningococcal, etc. Specify)             |                 |                 |                 |                 |                 |                 |

State reason if a vaccine is contraindicated: \_\_\_\_\_

\*BCG is a vaccination against Tuberculosis. This is not given in North America but it is common in Africa, Asia and parts of Europe and Great Britain

## Medical Fitness

**Directions:** Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

**Have you ever had, or do you currently have, any of the following conditions?**

|   |   |
|---|---|
| <p>1. Asthma Y / N</p> <p>2. Diabetes Y / N</p> <p>3. Blood disorders Y / N</p> <p>4. Allergy to pollen, latex, bee stings or foods? Y / N</p> <p>5. Allergy to medications? Y / N</p> <p>6. Concussion or head injury Y / N</p> <p>7. Seizure Y / N</p> <p>8. Frequent or severe headaches Y / N</p> <p>9. Heart problems, murmur Y / N</p> <p>10. Convulsive disorder Y / N</p> <p>11. Congenital disorder Y / N</p> <p>12. Auto immune disorders Y / N</p> | <p>13. Autism spectrum disorders Y / N</p> <p>14. Low or high blood pressure Y / N</p> <p>15. Low or high blood pressure Y / N</p> <p>16. Hemophilia, Sickle cell, other? Y / N</p> <p>17. Dizziness or passing out during or after exercise without known cause? Y / N</p> <p>18. Vision problems Y / N</p> <p>19. Bone/joint problems / Dislocated joints Y / N</p> <p>20. Upper or lower back pain Y / N</p> <p>21. Coughing, wheezing or shortness of breath in weather changes or normal condition? Y / N</p> <p>22. Surgery Y / N</p> |
|---|---|

**Explain (type of problem, treatment date, current treatment, etc.) all "yes" answers here (include relevant dates):**

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**Are there limitations on participation in athletics?  YES  NO**  
**If yes, please explain**

**List all medications here:**

| Medication Name | Purpose | Dosage | Frequency |
|-----------------|---------|--------|-----------|
|                 |         |        |           |
|                 |         |        |           |
|                 |         |        |           |

**Parent/Guardian Signature**

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
 Signature, Parent/Guardian

\_\_\_\_\_  
 Date of Signature: