



## 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>Phone: Home:</b>	<b>Work</b>				

Immunization						
VACCINE/DOSE	1	2	3	4	5	6
	(dd/mm/yy)	(dd/mm/yy)	(dd/mm/yy)	(dd/mm/yy)	(dd/mm/yy)	(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						
Other (Specify Hepatitis A, Meningococcal, BCG*, etc)						

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>
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**Explain all "yes" answers here (include relevant dates):**

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**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: