MT. BLUE CAMPUS

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PHYSICIAN'S EXAMINATION

MEDICAL AND IMMUNIZATION RELEASE

(to be completed by student's physician)

Student Name:	**Gender:**	**Date of Birth: / /** MONTH/DAY/YEAR	
Grade:	**School:**		
Height:	**Weight:**	**Pulse:**	**Blood Pressure:**
Visual Acuity: R | L	**Hearing: R db | L db**		**Body Mass Index:**

Does the student suffer from any of the following medical concerns?

YES	NO			YES	NO	
		Frequent Headaches				Toileting Problem
		Dizziness/Fainting				Behavior/Emotional Problem
		Seizures				Physical Limitation
		Vision Problem				Scoliosis
		Hearing Problem				Heart Disease
		Asthma/Chronic Cough				Chronic Illness
		Allergy				Learning Problems
		Frequent Abdominal Pain				Special Dietary Needs
		Diabetes				Dental Problems

Medical Concern	**Plan** (medications, services, follow-ups)

Immunizations

All children enrolled in a public or private school in Maine (USA) must have the immunizations listed on the Maine School Immunizations Requirements document. Each immunization entry must include the vaccine type, the date administered, and the name of the provider. As of September 1, 2021, only medical exemptions are allowable except as described in MRSA, Title 20-A §6355.

A minimum of:

5 (five) DTaP (diptheria, tetanus, pertussis) (4 DTaP if 4th is given on or after 4th birthday)

/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR

4 (four) Polio (3 Polio if the 3rd is given on or after the 4th birthday

/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR

2 (two) MMR (measles, mumps, rubella)

/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR

2 (two) Varicella (chickenpox) or reliable history of the disease

/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR	*Or Date of disease* / / MONTH/DAY/YEAR

1 (one) Tdap (tetanus, diphtheria, pertussis)

/ / MONTH/DAY/YEAR

1 (one) or 2(two) MCV4 (Meningococcal Conjugate Vaccine) (only one dose is required if the 1st dose is given on or after 16th birthday)

/ / MONTH/DAY/YEAR	/ / MONTH/DAY/YEAR

The student named on the other side may participate in a full school program including a vigorous physical education program and interscholastic athletics. (Specify limits in needed)

Physician Name (Printed):	
Physician Signature:	
Date of Exam:	