3650 Reed Road, Columbus, OH 43220
summer@wellington.org

Immunization and Medical Form for ages 3-5

Student's Name_____ **Grade**_____

Healthcare provider, check one:

_____ Exam entirely within normal limits

_____ Abnormalities as follows:

Restrictions:

Healthcare Provider's Signature _____**Date** _____

IMMUNIZATIONS Not all date boxes will be filled. A separate list may be attached.

	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr
DTaP DPT or DT	/ /	/ /	/ /	/ /	/ /	/ /
Td	/ /	/ /	/ /	/ /	/ /	/ /
Tdap (7th grade)	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
MMR	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal	/ /	/ /	/ /	/ /	/ /	/ /
HPV	/ /	/ /	/ /	/ /	/ /	/ /
Meningitis	/ /	/ /	/ /	/ /	/ /	/ /
Rotavirus	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
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Screening Tests	Date	Results
Muscle Balance		
Farsightedness		
Color		
Distance Acuity		Right Left
Hearing		Right Left

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