



**Acalanes Union High School District
Pre-High School Physical Examination (Physician's Report for School Use)**

You can complete this form on your own computer. To move from field to field, use the Tab key. You may then print the completed document and if desired, save the document template to your own computer.

In order to provide the best learning experience for the student, it is important that we have an understanding of the student's health status. Please complete this form and it will be given to the School Nurse. If you wish to discuss any health problem in more detail, please contact your School Nurse.

Date: _____ Student's Name: _____
 (Last) (First) (Middle)

School: Choose School Grade: Choose Grade Student ID#: _____
 (Full Name of School)

Date of Birth: _____ Gender: F M Class of: _____

PATIENT: Take this form with you to the physical examination.

PARENT'S AUTHORIZATION

I hereby give my consent to the AUHSD School Nurse to receive from or send any information to

Dr. _____ Phone: _____
 concerning my child _____

Required Signature: Parent/Guardian: _____ **Date:** _____

Name of Parent or Guardian: _____

DOCTOR - Please return this form, by mail, to the school indicated below:

<input type="checkbox"/> School Nurse Acalanes High School 1200 Pleasant Hill Road Lafayette, CA 94549	<input type="checkbox"/> School Nurse Campolindo High School 300 Moraga Road Moraga, CA 94556	<input type="checkbox"/> Registrar Ctr. Independent Study 1963 Tice Valley Blvd Walnut Creek, CA 94595	<input type="checkbox"/> School Nurse Las Lomas High School 1460 S. Main Street Walnut Creek, CA 94595	<input type="checkbox"/> School Nurse Miramonte High School 750 Moraga Way Orinda, CA 94563
---	--	---	---	--

Official documentation of immunizations required. Please attach a copy of the student's immunization record or complete the section below, providing month, day, and year of each dose.

VACCINE	DATE EACH DOSE WAS GIVEN					
	1 ST	2 ND	3 RD	4 TH	5 TH	Booster
POLIO (OPV OR IPV)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	--
DTP/DTaP/DT/Td (Diphtheria, tetanus & [acellular] pertussis OR tetanus & diphtheria only)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Tdap (tetanus, diphtheria, and pertussis)	--	--	--	--	--	___/___/___
MMR (Measles, mumps, and rubella)	___/___/___	___/___/___	--	--	--	--
HIB (Required only for child care and preschool)	___/___/___	___/___/___	___/___/___	___/___/___	--	--
HEPATITIS B	___/___/___	___/___/___	___/___/___	--	--	--
VARICELLA (Chickenpox)	___/___/___	___/___/___	--	--	--	--
HEPATITIS A (Not required)	___/___/___	___/___/___	--	--	--	--

TB SKIN TESTS	Type*	Date Given	Date Read	mm indur	Impression	Chest X-Ray (Necessary if skin test positive)
	<input type="checkbox"/> PPD Mantoux <input type="checkbox"/> Other	___/___/___	___/___/___		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Film Date: ___/___/___ Impression: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
	<input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other	___/___/___	___/___/___		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Person is free of communicable tuberculosis: <input type="checkbox"/> yes <input type="checkbox"/> no
	*If required for school entry, must be Mantoux unless exception granted by local health department.					

