Immaculate Conception Academy

NEW STUDENT
INFORMATION FORM

Date of Application _____

Student's Name ___
Last **First** **Middle**

Home Address
_____

City _____ State _____ Zip _____ Phone _____

Age ____ Birth Date _____ Sex ____ Birthplace _____

List the following if the child is Roman Catholic:

Sacrament	Date	Church	Location
Baptism	_____	_____	_____
Penance	_____	_____	_____
Holy Communion	_____	_____	_____
Confirmation	_____	_____	_____

Please give any other information regarding this student which you consider to be helpful to the faculty and/or the administration of Immaculate Conception Academy.

Immaculate Conception Academy

MEDICAL EXAMINATION
(To Be Completed By Physician)

Name: _____ Grade: _____

Date of Birth: _____ Social Security Number: _____

HEALTH HISTORY

Anemia	**____**	**Heart Disease**	**____**	**Rheumatic Fever**	**____**	**Allergies**	**____**
Chicken Pox	**____**	**Measles**	**____**	**Scarlet Fever**	**____**	**Ear Conditions**	**____**
Diabetes	**____**	**Mumps**	**____**	**Tuberculosis**	**____**	**Freq. Cold**	**____**
Sore Throat	**____**	**Epilepsy**	**____**	**Nephritis**	**____**	**Contact with TBC**	**____**
Asthma	**____**	**German Measles**	**____**	**Pneumonia**	**____**	**Operations**	**____**

Serious Injuries _____

Height _____	**Teeth _____**	**Skin (Non-Comm.) _____**
Weight _____	**Heart _____**	**Convulsive Disorder _____**
Ear (Otoscopic)_____	**Lungs _____**	**Nervous System _____**
Lymph Nodes _____	**Hernia_____**	**Speech_____**
Thyroid _____	**Genitourinary _____**	**Nutrition _____**
Nose_____	**Orthopedic_____**	**Other_____**
Scoliosis_____	**VISION: Rt. Eye_____**	**Lt. Eye _____**

Does the student exhibit any difficulty in the interpretation of visual, auditory, or tactile stimuli?

_____

May this student participate in Physical Education? _____

Within the previous year, has this student had any:

1. **Operation (specify)?_____**
2. **Special Medications or Treatments? (e.g. insulin, tranquilizers)**
   _____
   _____

Comments:

_____
_____
_____
_____

Physician's Signature_____ Date: _____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL OFFICE BY THE FIRST DAY OF SCHOOL

CERTIFICATE OF IMMUNIZATION

This is to certify that _____ _____
(first name) (last name)

_____ _____ _____
(grade) (age) (date of birth)

received the following immunizations:

	Date of 1st Immunization (Month, Day, Year)	**Date of 2nd Immunization (Month, Day, Year)**
*MMR (After one year of age) Measles, Mumps, Rubella	_____	_____
*HIB vaccine (Haemophilus Influenza Type B - Between 18 months and 5 years of age)	_____	_____
Hepatitis (Optional)	_____	_____
Varicella (or history of disease)	_____	_____

	Dates	**Date of Boosters**
Oral Polio Sabin (TOPV -	#1_____	#1_____
4 unless 3rd was after 4th	#2_____	#2_____
birthday)	#3_____	#3_____
	#4_____	#4_____
Diphtheria - DPT, DT or TD		
	#1_____	#1_____
(At least three doses)	#2_____	#2_____
	#3_____	#3_____

*Full doses only

** Tdap booster is now recommended to children starting at age 11-12 years. This replaces the previous use of Td. Also recommended for that age is the Meningococcal Conjugate Vaccine (Menactra). This vaccine was more widely given in the past to kids entering college.

Religious or Medical Exemption (Attached)

_____ _____
Physician's Signature **Date**

Physician's Stamp: