



CONCORDIA LUTHERAN SCHOOL

PRESCHOOL • ELEMENTARY SCHOOL • MIDDLE SCHOOL

A Ministry of Concordia Lutheran Church

RETURN TO SCHOOL BEFORE 1ST DAY OF SCHOOL

PHYSICIAN CERTIFICATE OF EXAMINATION FORM

Must be completed by child's physician

Name _____ Date of Birth ____/____/____

Allergies _____

Current Medications: (list name, dosage, and time)

1. _____ Dosage _____ Time _____

2. _____ Dosage _____ Time _____

3. _____ Dosage _____ Time _____

Height _____ Weight _____ B/P _____ Pulse _____

Eyes _____

Ears _____

Nose _____

Throat _____

Chest/Lungs _____

Heart _____

Abdomen _____

Hernia _____

Extremities _____

Musculoskeletal _____

Neurological _____

Skin _____

Lab Work (if indicated)

Hematocrit _____

Hemoglobin _____

Lead Level _____

Sickle Cell _____

Urinalysis _____

Other _____

Tuberculin Test (if indicated)

Type of test _____

Date _____

Results _____

Is this student physically fit to participate in all physical education programs?

Yes _____ No _____ If no, please explain _____

Please list any conditions that should be considered in planning this child's school day:

ENGAGING HEARTS AND MINDS

4245 LAKE AVENUE ▪ FORT WAYNE, IN ▪ 46815

PHONE: (260) 426-9922 x200 ▪ FAX: (260) 422-6980 ▪ E-MAIL: school@clscubs.org



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Student Name _____ Grade _____

IMMUNIZATION HISTORY

PLEASE ATTACH A COPY OF THE CHILD'S FULL IMMUNIZATION RECORD

All students must have an immunization record in the school office *before the first day of school*. This student MAY NOT attend school without a record of having received the required immunizations listed below or unless a medical OR religious exemption form has been filed with the school office.

Required vaccinations are as follows:

Kindergarten –5th Grades

DTaP (5) IPV (4) Hepatitis B (3) MMR (2) Varicella (2) Hepatitis A (2)

6th and 8th Grades

Previous listed plus additional Tdap (1) and MCV4 (1)

********These are the minimum doses that are necessary. All minimum ages and intervals for each vaccination as specified in the CDC guidelines must be followed to be considered valid in the State of Indiana .********

Printed/Stamped Name of Physician Completing this Form

Physician's Signature

Date

(rev ACNPSA 1/23)

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