

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough) } DPT	2	2
Tetanus or	3	
Tetanus		
Diphtheria } TD or		
Tetanus Td		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard or red measles, Rubelola)		
Mumps		
Rubella (German measles, 3-day measles)		
Varivax (chicken pox)		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Other vaccinations		

Health Care Recommendations (to be completed by a licensed health care provider)

have examined the above applicant within the past year. Date Examined _____

Height _____ Weight _____ Blood Pressure _____

Is this applicant is under the care of a physician for the following: _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? ____ Yes ____ No Does applicant have diabetes? ____ Yes ____ No

Are there any mental issues AIO should be aware of _____

Recommendations and Restrictions while at AIO:

Any treatment/medication to be continued (list specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc) _____

Does the students have any history of knee or back problems? _____

Activities to be encouraged or limited? Additional Health Information? _____

Health Care Provider's Signature (DO,PA,MD,NP) _____

Address _____ Phone _____

Date of Form Completion _____ By _____