CHILD’S IMMUNIZATION RECORD SIGNED BY DOCTOR

This is to certify that (child’s name) ___________________________________
DOB _________________was examined by me on (date)_________________.

1) Has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the State Department of Health for pre-school and school age children, or is to be exempted from these requirements for medical reasons.

IMMUNIZATION RECORD: (Please enter month, day and year)

DPT	1_______	2_______	3_______	4_______	5_______
POLIO	1_______	2_______	3_______	4_______	
HIB	1_______	2_______	3_______	4_______	
HEPB	1_______	2_______	3_______		

MEASLES, MUMPS, RUBELLA – usually combined as MMR_______
If separate: MEASLES______MUMPS_______RUBELLA_____
*The 5th DPT and the 4th Polio are normally administered just prior to Kindergarten.

2) Based upon his/her medical history and physical condition at the time of this examination, is free from all apparent communicable disease and is in good health for enrollment in school (ages 2.5 yrs thru 9 yrs).

Physician’s Signature____

Street Address____

City, State, Zip____

Telephone # ____

Return via: Fax (513) 271-1684, email: springseastschool@cinci.rr.com,
or mail to Springs East School 9429 Loveland-Madeira Rd, Cincinnati, OH 45242