FAIR ACRES
COUNTRY DAY SCHOOL

35 FAIR ACRES DR. MARSTONS MILLS, MA 02648
PH (508) 420-3288 FAX (508) 420-1710
www.FairAcresCapeCod.com

Physical Form

Dear Physician:_____ is enrolled in an early childhood program which is licensed by the Department of Early Education and Care. The Department of Early Education and Care regulations require that the Medical History and Immunizations Form be completed and signed by the child's physician or source of health care. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of child_____DOB_____
Address_____Phone_____
Name of Parents_____
Address_____

Date of Examination of Child_____

What is your opinion concerning the child's general health and appearance?

_____
_____

Has this child been **screened for lead** poisoning? Yes_____ No_____
If Yes, date screened_____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the school or day care provider? If so, please detail below:

_____
_____
_____

Physician's Signature_____Date_____
Comments:_____

Please return to: FAIR ACRES COUNTRY DAY SCHOOL
35 FAIR ACRES DRIVE
MARSTONS MILLS, MA O2648

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Sex: M F**

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date: / /**

Signature:

Facility name: