

Immunization Record

Name: _____ Date of Birth _____

Name of Parent/Guardian _____

All students enrolled at Discovery must provide proof that they have had, or are in the process of completing all of the following immunizations before entering school:

Required Vaccines:	Recommended Vaccines: Highly Recommended *
Diphtheria, Tetanus, Pertussis (DTP Series)	Typhoid
Measles, Mumps, Rubella (MMR series)	Hib (Haemophilus Influenza Type b)
Poliomyelitis (OPV/IPV Series)	Rabies
Yellow Fever	Meningococcal *
Tuberculosis PPD Skin Test or BCG Vaccination	Hepatitis A and B
	Varicella (Chickenpox) *

Please attach a copy of your child's complete immunization record OR have the following record COMPLETED BY A PHYSICIAN, NURSE or HEALTH AUTHORITY.

REQUIRED IMMUNIZATION	ENTER DATE EACH IMMUNIZATION WAS GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3		
Poliomyelitis (OPV or IPV)	1	2	3		
Measles, Mumps, Rubella (MMR 1 & 2)	1	2	Confirmation of Measles, Mumps, Rubella immunity:		
Yellow Fever	1				
Tuberculosis PPD Test or BCG Vaccination	PPD Test Results: _____ mm of duration				
Other: Smallpox	Other: Chicken Pox				
Other: Hepatitis	Other:				

To the best of my knowledge, the person above has received the above immunizations.

Physical Examination

I certify that _____ has been examined and

he/she is physically fit to participate in all school physical athletics and activities
he/she is restricted from participation in school physical athletics/activities as follows

Name of Doctor: _____ Signature: _____

Name of Hospital: _____ Date: _____

**DISCOVERY SCHOOL
MEDICAL CONSENT FORM**

I, the undersigned parent of the following child(ren):

give my consent to the Administration of Discovery School to provide treatment of *minor injuries* sustained by my child(ren) while in the care and custody of the school.

Name (Please Print)

Signature and Date

OR

have provided alternate instructions (attached in writing) concerning treatment of *minor injuries* sustained by my child(ren) while in the care and custody of the school.

Name (Please Print)

Signature and Date

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The point of contact in a **medical emergency** is: _____

(Please print name and phone number clearly—your child's safety may depend on it.)

The alternate point of contact in a **medical emergency** is: _____

(Please print name and phone number clearly—your child's safety may depend on it)

If **immediate** medical treatment is needed my child should be taken to: _____

(Please print name, address and phone number clearly—your child's safety may depend on it)

I understand that the school will exercise due diligence to ensure the security and well being of my child(ren) and to comply with any written instructions from me concerning the emergency treatment for them. I agree to hold the school blameless and free of liability for any loss, damage or injury sustained by my child(ren) or myself due to circumstances beyond the reasonable control of the school.

Name (Please print)

Signature

Date