The Children's Workshop, Inc.

PO Box 493
North Kingstown, RI 02852
(401) 884-8966

Physician's Record of Immunization and Pre-Admission Examination

Child's Name: ___________________________________ Date of Birth: __________ Sex: _______

Address: ____

Immunizations and Screenings **(record month/day/year)**

	Date	Date	Date	Date	Date	Date
DPT (Diphtheria, Tetanus, Pertusis)						
DT (Pediatric Diphtheria, Tetanus)						
DtaP						
Hepatitis B						
HIB (note type)						
Lead screening						
Lead screening results						
Measles						
MMR (Measles, Mumps, Rubella)						
Mumps						
Polio						
PPD						
PPD results in mm.						
Rubella						
Td (Adult Tetanus, Diphtheria)						
Tetanus						
Varicella (Chicken Pox)						

Examination

Date of physical examination: ____________________

Height: ___________ Weight: ______________ Blood Pressure: _________________

Please specify any abnormalities: ____

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____

Please see reverse

Visual Acuity

Right eye: ________________ Left eye: ___________________

Glasses needed? Yes No

Auditory Screening

Performed? Yes No Degree of loss: ____________________

Dental Screening

Teeth decayed? Yes No
Teeth missing? Yes No
Teeth filled? Yes No

Can this child participate in usual school activities? Yes No

Please specify any limitations: ____

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____ ____________________
Physician's signature Date

____
Physician's address and phone number