



Iowa Department of Public Health Certificate of Immunization

Name Last: _____ First: _____ Address: _____
Parent/Guardian: _____ Date of Birth: _____ Phone: _____
I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.
Signature: _____ Date: _____
Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/Td/Tdap	Vaccine	Date Given	Doctor / Clinic / Source
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
Haemophilus influenzae type b Hib			
Hepatitis B			

Varicella Chicken Pox <i>If applicant has a history of natural disease write "Immune to Varicella"</i>	Vaccine	Date Given	Doctor / Clinic / Source
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

Monticello Community Schools
Medical Exam Form

Name _____ Date of Birth _____

Parent/Guardian Name _____

Doctor/Clinic Name _____

Health History:

Condition:	Date(s)
Hepatitis	_____
Pneumonia	_____
Strep Infection	_____
Chicken Pox	_____
Bladder/Kidney Trouble	_____
Seizure Disorder	_____
Ear Infection	_____

Major Injuries/Surgeries: _____

Allergies: _____

Physical Exam:

Ht. _____ Wt. _____ BP _____ P _____

Urinalysis _____

HGB _____

General Exam:

Head _____	Throat _____	GU _____
Eyes _____	Neck _____	Ext. _____
Ears _____	Lungs _____	
Nose _____	Heart _____	
Mouth _____	Abd. _____	

Conditions which could effect school work _____

*** Lead Testing: Results _____ Date _____

Immunization Plan: IPV #4 _____ Dtap #5 4 _____ MMR #2 4 _____

Hep B _____ Varicella Vac _____

- Please fill out Immunization form on back of Medical Exam Form, or attach signed copy from IRIS.

Examiner's Signature _____

Date: _____