

Email: [registrar@stmarysdominican.org](mailto:registrar@stmarysdominican.org); FAX: (504) 866-5958;  
 Mail: SMDHS, 7701 Walmsley Avenue, New Orleans, LA 70125



## St. Mary's Dominican High School Health Information Form

STUDENT NAME (Last)	(First)	(Middle)	BIRTHDATE	PHONE
ADDRESS			PARISH	
PARENT or GUARDIAN			FAMILY PHYSICIAN	

**TO BE COMPLETED BY FAMILY PHYSICIAN:**

### PHYSICAL EXAMINATION

WEIGHT		HEIGHT		TEMPERATURE	
PULSE		RESPIRATION		BLOOD PRESSURE	
EYES	EARS	NOSE		THROAT	
LUNGS		HEART		BLOOD	
NERVOUS DISTURBANCES					
DEFORMITIES & ABNORMALITIES					
DIAGNOSIS					
This student (can/ cannot) participate fully in a high school physical education program. Comments:					
Is this student on any regular medication which must be administered during the school day? (Yes/ No) Comments:					
SIGNATURE OF ATTENDING PHYSICIAN (also required on reverse)				PHONE NUMBER	

**(OVER)**

# STUDENT IMMUNIZATION REPORT

Parents are required by law to furnish the school with a valid, up-to-date copy of their daughter's immunization record. Louisiana Statute 17:170 mandates that all students be properly immunized in order to attend any school within the state. The minimum immunization requirements for students to be eligible to attend and remain in school are:

- 4 DTP (Diphtheria/ Tetanus/ Pertussis combined)**
- 3 Oral Polio**
- 1 MMR (Measles/ Mumps/ Rubella)**

The last DTP and Polio must have been given after the fourth birthday. It is recommended that a student be given a TD at 14 – 16 years of age and every 10 years thereafter. The law does allow for letters of dissent. However, no letter will be accepted except those signed by the parent or guardian at the school, in the presence of a school official.

**TO BE COMPLETED BY FAMILY PHYSICIAN:** Please complete the immunization record chart below and verify that the patient's immunization dates have been entered into the Louisiana Immunization Network for Kids Statewide (LINKS) system.

DATES OF IMMUNIZATIONS								
VACCINES	1st	2nd	3rd	4th	5th	6th	7th	8th
DTaP/DT								
Td								
TDaP								
Polio								
HiB								
PCV7								
MCV4								
HBV								
MMR								
VAR								
HPV								
Influenza								
Rotavirus								

**CHOOSE ONE OF THE BELOW OPTIONS:**

**OPTION 1:**

( ) Patient has completed the immunizations required by state law.  
Her next TD booster is due \_\_\_\_\_ to fulfill requirements.

**OPTION 2:**

( ) Patient is still in the process of completing the immunizations required by state law.  
Number of doses needed to fulfill requirements:  
\_\_\_\_\_ DTP/TD    \_\_\_\_\_ Polio    \_\_\_\_\_ MMR

<b>SIGNATURE OF ATTENDING PHYSICIAN</b>	<b>DATE</b>