PHYSICIAN'S CERTIFICATE
(Chapter 150, Acts 1969, and
Regulation HTO Immunization Requirements
for School Enrollment)
(House Enrolled Act #1352)

ST. PAUL'S
LUTHERAN SCHOOL

**Parent/Guardian, please print and fully complete:**

| | | | |
|---|---|---|---|
| Student's Last Name | | First | Middle |
| Street Address | | City | State |
| Birthdate | Grade | Gender | |
| Parent/Guardian | | Phone Number | |

**IMMUNIZATION SCHEDULE**
**ATTACH IMMUNIZATION HISTORY**

## Required and Recommended School Immunizations, Indiana 2024-2025

Updated 1.30.2024

| Grade | Required | | Recommended |
|---|---|---|---|
| Pre-K | 3 Hepatitis B<br>4 DTaP (Diphtheria, Tetanus and Pertussis)<br>3 Polio | 1 Varicella (Chickenpox)<br>1 MMR (Measles, Mumps and Rubella)<br>2 Hepatitis A | Annual influenza<br>COVID-19 |
| K-5 | 3 Hepatitis B<br>5 DTaP<br>4 Polio | 2 Varicella<br>2 MMR<br>2 Hepatitis A | Annual influenza<br>COVID-19 |
| 6-11 | 3 Hepatitis B<br>5 DTaP<br>4 Polio<br>2 Varicella | 2 MMR<br>2 Hepatitis A<br>1 MCV4 (Meningococcal)<br>1 Tdap (Tetanus, Diphtheria and Pertussis) | Annual influenza<br>2 or 3 HPV (Human papillomavirus)<br>COVID-19 |
| 12 | 3 Hepatitis B<br>5 DTaP<br>4 Polio<br>2 Varicella | 2 MMR<br>2 Hepatitis A<br>2 MCV4<br>1 Tdap | Annual influenza<br>2 or 3 HPV<br>2 MenB (Meningococcal)<br>COVID-19 |

**HepB:** The minimum age for the third dose of Hepatitis B is 24 weeks of age.

**DTaP:** Four doses of DTaP/DTP/DT are acceptable if fourth dose was administered on or after the fourth birthday.

**Polio*:** Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the fourth birthday and at least six months after the previous dose.
*For students in grades K-12, the final dose must be administered on or after the fourth birthday and be administered at least six months after the previous dose.

**Varicella:** Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 12th grade. Parent report of disease history is not acceptable.

**Tdap:** There is no minimum interval from the last Td dose.

**MCV4:** Individuals who receive their first dose on or after their 16th birthday only need one dose of MCV4.

**Hepatitis A:** The minimum interval between first and second dose is six calendar months. Two doses are required for all grade levels.

For additional immunization information, visit: in.gov/health/immunization
or call **1 (800) 701-0704** during normal business hours.

**To be completed by physician - EXAMINATION RECORD**

______________________________________________

NAME AGE GENDER

Physical and Nutritional Development ____________ Mental and Emotional Development ____________

SKIN ____________ Hair and Scalp____________

B/P ________ HEIGHT ________ WEIGHT ________

NOSE AND THROAT ________ Palpable Nodes ________ Tonsils CHEST ________ Lungs ________ Heart

ABDOMEN ____ Hernia ____ Inguinal ____ Femoral ____ Umbilical ____________ Other

EXTREMITIES ______________________________

ORTHOPEDIC DEFECT______________________________

Surgeries (Specify): ______________________________

Serious Accidents (Specify): ______________________________

**Life threatening allergies or medical conditions: (Specify)**

______________________________________________

**PRESCRIPTION MEDICATION**: Child takes the following prescription medication on a regular or daily basis (please specify name, dose, and reason). Any medication taken during the school day must be sent to school in original packaging along with physician's Prescription Medication instruction form to be effective for the current school year only.

______________________________________________

______I recommend the **regular school program** including the **regular program of physical activity** (Regular Physical Education includes exercises such as: Elementary Grades - running, skipping and jumping; Middle grades - competitive or intramural basketball, baseball, touch or flag football, track, tennis, volleyball, cheerleading, swimming, and soccer, etc.). (If there is anything about this child's condition that will influence or interfere with regular school life or regular program of physical activity, please note)

COMMENTS______________________________

______I recommend **modified physical activity***** (specify degree and reason) (Restricted Physical Education includes less strenuous activities such as: gym assistant, official, and scorekeeper) *** Recommendations for Modified Physical Activity are effective for the current school year only, unless specified below:

COMMENTS: ______________________________

**FAMILY HISTORY**

Give state of health or cause of death: ________ Mother ________ Father ________ Sisters ________ Brothers

Sickness in the home, please describe:______________________________

____________ ✍ ______________________________

Date Physician's Signature DO MD Nurse Practitioner

______________________________________________

Physician's Printed Name/Address/Phone

**PLEASE COMPLETE OTHER SIDE**