



ST. JOHNSBURY ACADEMY

St. Johnsbury Vermont, 05819 | Phone: (802) 748-8171 | Fax: (802) 748-5463 | www.stjohnsburyacademy.org

Student Name _____

Immunizations

Diphtheria/Pertussis/Tetanus

Date of dose 1 MONTH / DAY / YEAR _____

Date of dose 2 _____ / _____ / _____

Date of dose 3 _____ / _____ / _____

Date of dose 4 _____ / _____ / _____

Date of dose 5 _____ / _____ / _____

Last Td/Tdap _____ / _____ / _____

if not within the last 10 years IMMUNIZE NOW

_____ / _____ / _____

Polio

Date of dose 1 MONTH / DAY / YEAR OPV IPV

Date of dose 2 _____ / _____ / _____ OPV IPV

Date of dose 3 _____ / _____ / _____ OPV IPV

Date of dose 4 _____ / _____ / _____ OPV IPV

HPV Vaccine: (highly recommended)

Check the appropriate box: Gardasil Other

Date of dose 1 MONTH / DAY / YEAR _____

Date of dose 2 _____ / _____ / _____

Date of dose 3 _____ / _____ / _____

Measles/Mumps/Rubella (MMR)

Date of dose 1 MONTH / DAY / YEAR _____

Date of dose 2 _____ / _____ / _____

Tuberculin Test

TB skin test Date: MONTH / DAY / YEAR _____

Results _____ mm in duration

(positive over 10mm in duration)

If **Positive skin test**: Date of chest x-ray: MONTH / DAY / YEAR _____

Results: _____

Medication _____ Started: MONTH / DAY / YEAR _____

Date ended: MONTH / DAY / YEAR _____

Previous BCG Date: MONTH / DAY / YEAR _____

Hepatitis B

Date of dose 1 MONTH / DAY / YEAR _____

Date of dose 2 _____ / _____ / _____

Date of dose 3 _____ / _____ / _____

Meningococcal Vaccine (REQUIRED by VT law)

Check the appropriate box: Menomune Menactra

Date of dose 1 MONTH / DAY / YEAR _____

Varicella (REQUIRED if no history of disease)

Date of dose 1 MONTH / DAY / YEAR _____

Date of dose 2 _____ / _____ / _____

History of disease Date: _____ / _____ / _____

Permission for Influenza Vaccine: HIGHLY RECOMMENDED

Please check one:

Has my permission to receive the influenza vaccine

Does NOT have my permission to receive the influenza vaccine

X SIGNATURE OF PARENT/GUARDIAN

DATE

X SIGNATURE OF PHYSICIAN

DATE

Prior to your student entering St. Johnsbury Academy, he/she must have completed the Vermont state required immunizations. All students who do not have this proof will be inoculated locally at the family's expense.

I authorize St. Johnsbury Academy to complete the necessary series of immunizations.

X PARENT/GUARDIAN SIGNATURE

DATE

Medical History

Do you have or have you ever had?	YES	NO	Comment
ADHD /Learning Disability			
Alcohol/Substance use			
Anemia/Blood disorder			
Asthma/Lung problems			
Back problems			
Cancer/Tumor			
Chest pain/Shortness of breath			
Counseling/Psychotherapy			Doctors Name _____ Phone number _____
Dental problems			
Depression			
Diabetes			
Ear, Nose, Throat problems			
Eye problems			
Fainting/Loss of consciousness			
Fractures/Sprain/Dislocation			
Headaches			
Head injury/Concussion			
Heart Disease			
High Blood Pressure			
Intestinal/Digestive problems			
Kidney disease/Bladder			
Measles			
Mononucleosis			
Mumps			
Pneumonia			
Rheumatic Fever			
Seizures			
Significant Anxiety			
Sinusitis			
Skin problems			
Special Diet			
TB			
Thyroid/Hormone problems			
Tobacco Use			
Weight change/Anorexia			
ALLERGIES			
			Date of last Dental exam / /

Medical History CONTINUED

Medication Consent for OTC's (over the counter medicines)

Medication	Yes	No
Tylenol		
Ibuprofen		
Sudafed (cold medicine)		
Antacid		
Benadryl		
Cough suppressants		
Anti-Diarrhea		
Laxative		
Other		
Medication prescribed by the Physician		

X SIGNATURE OF PARENT/GUARDIAN

DATE