





# YES CANDIDATURA DO ESTUDANTE

EXTRATO DE SAÚDE DO CANDIDATO – CONT.

Nome do estudante (Apelido, Nome, Sobrenome)

Insira números nos espaços:

Tipo de sangue: \_\_\_\_\_ Altura: \_\_\_\_\_ Peso: \_\_\_\_\_ Pressão do sangue: \_\_\_\_\_ Gravidade Urinálise Específica: \_\_\_\_\_

Alb: \_\_\_\_\_ Açúcar: \_\_\_\_\_ Visão sem óculos: OD \_\_\_\_\_ OS \_\_\_\_\_ Visão com óculos: OD \_\_\_\_\_ OS \_\_\_\_\_

Audição no ouvido direito \_\_\_\_\_ Audição no ouvido esquerdo \_\_\_\_\_

## HISTORIAL DE IMUNIZAÇÃO

Pupils enrolled in kindergarten through grade 12 in the United States are required to have written proof that they have been immunized against poliomyelitis, DPT (diphtheria, tetanus, pertussis), measles, mums and rubella. Failure to do so is cause for exclusion from school.

1. Polio (Trivalent Oral – TOPV): 3 or more doses of trivalent oral polio vaccine (TOPV). (An additional dose is required if last dose was received before the age of 4 years.)
2. Diphtheria-tetanus-pertussis (DPT) or diphtheria-tetanus (TD) 7 years and older: 4 or more doses of DPT, DT (pediatric) or TD (adult) vaccine or a combination thereof, including a booster within the past ten years.
3. Measles (rubeola, 10-day measles): 1 dose, to include booster within the last 10 years, or physician-verified disease.
4. Rubella (three-day measles): 1 dose, to include booster within the last 10 years, or physician-verified disease.
5. Mumps vaccine: 1 dose, to include booster within the last 10 years, or physician-verified disease.
6. Hepatitis B vaccine: complete series of shots
7. Hepatitis A vaccines: at least 1 dose. If student has already completed 3 doses, please give dates.

Vaccine	Date each dose was given				
	1st M/D/Y	2nd M/D/Y	3rd M/D/Y	4th M/D/Y	5th M/D/Y
Polio (TOPV)					
DTP and/or TD (diphtheria-tetanus-pertussis or whooping cough and/or tetanus and diphtheria only)					
Varicella			If no immunization, provide date student had Varicella ___/___/___		
Measles (rubeola – 10 day, red measles)			If no immunization, provide date student had Varicella ___/___/___		
Rubella (German measles – 3 day measles)			If no immunization, provide date student had Varicella ___/___/___		
Mumps			If no immunization, provide date student had Varicella ___/___/___		
Hepatitis B					
Hepatitis A					
BCG					

If no BCG vaccine, student must have had a TB test within the past year: Date of test \_\_\_ / \_\_\_ / \_\_\_

Tuberculin skin test: + - If positive, report of negative x-ray and copy of x-ray required

Type of test:  PPD  Mantoux Chest x-ray + - Date of x-ray: \_\_\_ / \_\_\_ / \_\_\_

Your opinion of the state of the student's health:  Excellent  Good  Fair  Poor

I, the undersigned, have reviewed the medical history of the applicant and given a thorough physical examination and certify that all important medical information has been noted on this form and that nothing relevant has been omitted.

Physician's signature

Name (print)

Address

Date

