

EVANSVILLE DAY SCHOOL HEALTH FORM

Physical Examination Record

(To be filled out only by a physician)

To be completed and signed by a physician yearly. This form must be completed for students entering the following grades: JrPK, kindergarten, sixth and ninth grades, and all new students.

Name _____ Date _____ Grade _____

Address _____ Phone No. _____

Date of Birth _____ Sex _____ Family Physician _____

PHYSICAL EXAMINATION

(Code: No Defect-0; Defect-Note)

1. Height (in inches) _____ Weight _____

2. Eyes: required grades 1,3,8

Vision (Snellen) Right _____

Left _____

Glasses Right _____

Left _____

Audiometer required grades 1,4,7,10

3. Ears: Right _____

Left _____

4. Teeth _____ Caries _____

5. Nose _____

6. Throat _____

7. Lymph Nodes _____

8. Thyroid _____

9. Heart _____

10. Blood Pressure _____

11. Lungs _____

12. Abdomen _____

13. Hernia _____

14. Orthopedic Impairments _____

15. Scoliosis Screening-required gr. 5,7,9 _____

16. Nutrition _____

17. Skin _____

18. Nervous Symptoms _____

19. Menstrual History _____

20. Ano-rectal _____

21. External Genitals _____

22. General Condition _____

23. History of severe illnesses, injuries or surgeries _____

24. Ongoing Medical Concerns _____

Circle abbreviation of Immunization administered

RECORD OF REQUIRED IMMUNIZATIONS

DPT/DTaP 1. _____ MMR 1. _____

DPT/DTaP 2. _____ 2. _____

DPT/DTaP 3. _____ 3. _____

DPT/DTaP 4. _____ 4. _____

DPT/DTaP 5. _____

DPT/DTaP 6. _____

DPT/DTaP 7. _____

Td Booster 1. _____ Varicella 1. _____

2. _____ 2. _____

3. _____

4. _____

Polio Vaccine Hepatitis B

OPV/IPV 1. _____ 1. _____

OPV/IPV 2. _____ 2. _____

OPV/IPV 3. _____ 3. _____

OPV/IPV 4. _____

OPV/IPV 5. _____ HIB

OPV/IPV 6. _____ 1. _____

OPV/IPV 7. _____ 2. _____

Other

1. _____

2. _____

TESTS

Tuberculin: Type _____ Date _____

Results: _____ X-Ray _____

Lead Screen: Date _____ Results _____

Sickle Cell Anemia: Yes _____ No _____ Results _____

Urinalysis: Date _____ Results _____

Allergies _____

Physicians Recommendations

I recommend medical or dental attention to the following conditions: _____

Student physically fit to participate in physical education? Yes _____ No _____

Date _____ Print Physician's name _____ Signature of Physician _____

PLEASE COMPLETE THIS FORM AND RETURN TO THE FRONT OFFICE BY THE FIRST DAY OF SCHOOL OR AS SOON AS AN APPOINTMENT CAN BE SCHEDULED.

*****LIST MEDICATIONS TAKEN SOMEWHERE ON THE FORM*****