EVANSVILLE DAY SCHOOL
Independent • Bold • Rewarding
Discover Why.

Student Name ______________________________

(To be completed only by a physician)

This form must be completed annually for students entering grades Jr. Pre-K, Kindergarten, 5, 9, and all new students.

Address ______________________ Date ______________________
Date of Birth ______________________ Physician's Name ______________________
Sex ______________________ Phone Number ______________________

PHYSICAL EXAMINATION		RECORD OF REQUIRED IMMUNIZATIONS			
(code: No Defect = 0; Defect = Note		*Circle abbreviation of immunization administered*			
Height (in inches)		DPT/DTaP 1		MMR 1	
Weight		DPT/DTaP 2		MMR 2	
Eyes: required grades 1,3, & 8		DPT/DTaP 3		HPV	
Vision (Snellen) Right		DPT/DTaP 4		HPV	
Vision Left		DPT/DTaP 5		HPV	
Glasses Right					
Glasses Left				Varicella 1	
Audiometer required grades 1,4,7, & 10				Varicella 2	
Ears Right		Tdap		Hepatitis B	
Ears Left		MCV 4		Hepatitis B	
Teeth		MCV 4		Hepatitis B	
Caries				Hepatitis B	
Nose				Hepatitis A	
Throat		Polio Vaccine		Hepatitis A	
Lymph Nodes		OPV/IPV			
Thyroid		OPV/IPV		TESTS	
Heart		OPV/IPV		Tuberculin	
Blood Pressure		OPV/IPV		Type	Date
Lungs				Results	XRay
Abdomen				Lead Screen	
Hernia				Date	Results
Orthopedic Impairments		Other:		Sickle Cell Anemia	
Scoliosis Screening (required grades 5,7 &9)		Allergies:		(circle) Yes/No	Results
Nutrition		Ongoing Medical Concerns:		Urinalysis	
Skin				Date	Results
Nervous System		History of severe illnesses, injuries or surgeries:			
Menstrual History					
Ano-rectal		Current Medications:			
External Genitals					
General Condition					

Physicians Recommendations:

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

______________________ ______________________ ______________________
Date **Physician's Name (printed)** **Physician's Signature**

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.