

EVANSVILLE-VANDERBURGH SCHOOL CORPORATION
HEALTH SERVICES DEPARTMENT
EVANSVILLE, INDIANA

Home Room Teacher _____

Physical Examination Record
(To be filled out only by a physician)

Name _____ Grade _____ Date _____

Address _____ Phone No. _____

Date of Birth _____ Sex _____ Family Physician _____

PHYSICAL EXAMINATION

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

- 1. Height (in inches) _____ Weight _____
- 2. Eyes:
 - Vision (Snellen) Right _____
 - Left _____
 - Glasses Right _____
 - Left _____
- 3. Ears: Right _____ Left _____
- Hearing: 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 _____
- 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. _____ | |
| DPT/DTaP 5. _____ | Hepatitis B |
| DPT/DTaP 6. _____ | 1. _____ |
| | 2. _____ |
| Td / Tdap 1. _____ | 3. _____ |
| 2. _____ | |
| 3. _____ | HIB 1. _____ |
| 4. _____ | 2. _____ |
| | 3. _____ |
| | 4. _____ |
| Polio Vaccine | |
| OPV/ IPV 1. _____ | |
| OPV/ IPV 2. _____ | Pevnar 1. _____ |
| OPV/ IPV 3. _____ | 2. _____ |
| OPV/ IPV 4. _____ | 3. _____ |
| OPV/ IPV 5. _____ | 4. _____ |
| OPV/ IPV 6. _____ | |
| | Varicella |
| Meningococcal 1. _____ | 1. _____ |
| MCV4 / MPSV4 | 2. _____ |
| Other 1. _____ | HPV 1. _____ |
| 2. _____ | 2. _____ |
| | 3. _____ |

TESTS

- Tuberculin: Type _____ Date _____
- Results: _____ X-Ray _____
- Lead Screen : Date _____ Results _____
- Sickle Cell Anemia: Yes _____ No _____ Results _____
- Urinalysis: Date _____ Results _____
- Allergies: _____
- _____
- _____

Physician s 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 RETURN TO THE SCHOOL NURSE