EVANSVILLE CHRISTIAN SCHOOL

PHYSICAL EXAMINATION AND IMMUNIZATION RECORD
(to be completed by a physician)

Name _____ Grade _____ Homeroom Teacher _____
Last First Middle
Address _____ Telephone _____

Date of Birth _____ Sex _____ Family Physician _____

PHYSICAL EXAMINATION

(CODE: No defect - 0; Defect - Note)

Height _____ Weight _____
Eyes _____
Vision (Snellen) Right _____
Left _____
Glasses Right _____
Left _____
Ears Right _____
Left _____
Teeth _____
Caries _____
Nose _____
Throat _____
Lymph Nodes _____
Thyroid _____
Heart _____
Blood Pressure _____
Lungs _____
Abdomen _____
Hernia _____
Orthopedic Impairments _____
Posture _____
Nutrition _____
Skin _____
Nervous Symptoms _____
_____
Menstrual History _____
Ano-rectal _____
External Genitals _____
General Condition _____
History of severe illnesses, injuries, or surgeries
_____
_____

RECORD OF IMMUNIZATIONS

DPT/DTaP 1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Td/Tdap 1. _____
2. _____
3. _____
4. _____

Polio Vaccine
OPV/IPV 1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Meningococcal
MCV4/MPSV4 1. _____

Other 1. _____
2. _____
3. _____

MMR 1. _____
2. _____
3. _____

Hepatitis A
1. _____
2. _____

Hepatitis B
1. _____
2. _____
3. _____
4. _____

HIB 1. _____
2. _____
3. _____
4. _____

Prevnar
1. _____
2. _____
3. _____
4. _____

Varicella 1. _____
2. _____

TESTS
Tuberculin Date _____
Results: _____ X-Ray _____
Lead Screen: Yes _____ No _____ Results: _____
Sickle Cell Anemia: Yes ____ No ____ Results: _____
Urinalysis: Date _____ Results: _____
Allergies/Other: _____
_____

PHYSICIAN'S RECOMMENDATIONS

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

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

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

PLEASE RETURN TO THE HEALTH COORDINATOR

PAST HEALTH HISTORY

(To be completed by parent)

NAME _____ Birth Date _____ Sex _____ Grade _____
Last First Middle Month-Day-Year

Address _____ Telephone _____

Number of Children in Family _____ Name of Family Doctor _____ Name of Family Dentist _____

(Use the reverse side of this record as needed for additional notations.)

A. GENERAL HEALTH

1. Eye Symptoms
   wear glasses _____
   Age when received glasses _____
2. Ear Symptoms
   Hearing _____
   Earaches (explain) _____
   Discharging ear _____
3. High fever (explain) _____
4. Fainting spells (explain) _____
5. Convulsions (date and cause) _____
6. Dental problems _____
7. Speech difficulty _____
8. Nervous habits
   Temper tantrums _____ Bed wetting _____
   Thumb sucking _____ Nail biting _____
   Other _____ Cries easily _____
9. Medications (names) _____
   Are they taken regularly? _____
   Reason? _____
10. Diabetes
    Is there any diabetes in family? _____
    Give relationship _____
11. Tuberculosis contacts (Who?) _____
    When? _____

B. DISEASES AND CONDITIONS (Date)

Whooping Cough _____
Chicken Pox _____
Measles - Rubella _____
Rubella (3 day) _____
Mumps _____
Scarlet Fever _____
Strep Throat _____
Rheumatic Fever _____
Mono _____
Poliomyelitis _____
Bronchitis _____
Pneumonia _____
Hepatitis _____
Osgood-Schlatter _____
Epilepsy _____
Nose Bleed _____
Asthma _____
Eczema _____
Allergies (specify) _____
_____
Other _____
_____

C. OPERATIONS (type of surgery and dates)

_____
_____

D. INJURIES (explanation and dates)

_____
_____

E. OTHER

_____
_____

Is there any health condition that would be harmful to others? _____ If so, please list and explain this condition.

_____
_____

Please list directions for modification of the program if special attention is needed for a medical condition.

_____

_____ _____
Date Signature of parent or guardian