

HEALTH DEPARTMENT-NURSING DIVISION
EVANSVILLE, INDIANA

PHYSICAL EXAMINATION RECORD

(To be completed by your doctor)

Name _____ Date _____ Grade _____

Last First MI

Address _____ Telephone _____

Date of Birth _____ Sex _____ Physician _____

Month/Day/Year

PHYSICAL EXAMINATION

(Code: No Defect – 0; Defect – Note)

Weight _____ Height(inches) _____

Eyes _____

Vision (Snellen) Right _____

Left _____

Glasses Right _____

Left _____

Ears: Right _____

Left _____

Hearing: Right _____

Left _____

Teeth: _____ Caries: _____

Nose _____

Throat _____

Lymph Nodes _____

Thyroid _____

Heart _____

Blood Pressure _____

Lungs _____

Abdomen _____

Hernia _____

Orthopedic Impairments _____

Scoliosis Screenng _____

Nutrition _____

Skin _____

Nervous Symptoms _____

Menstrual History _____

Ano-rectal _____

External Genitals _____

General Condition _____

History of severe illnesses, injuries or surgeries:

Ongoing Medical Concerns: _____

Circle abbreviation of Immunization administered
RECORD OF REQUIRED IMMUNIZATIONS

DPT/DTaP 1. _____

DPT/DTaP 2. _____

DPT/DTaP 3. _____

DPT/DTaP 4. _____

DPT/DTaP 5. _____

MMR

1. _____

2. _____

3. _____

Varicella

Td/Tdap 1. _____

1. _____

2. _____

Polio Vaccine

OPV/IPV 1. _____

OPV/IPV 2. _____

OPV/IPV 3. _____

OPV/IPV 4. _____

OPV/IPV 5. _____

Hepatitis B

1. _____

2. _____

3. _____

HIB

Meningococcal

MCV4/MPSV4

1. _____

2. _____

1. _____

2. _____

3. _____

Prevnar

HPV 1. _____

2. _____

3. _____

1. _____

2. _____

3. _____

Hep A 1. _____

2. _____

4. _____

Other 1. _____

2. _____

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

Print Physician's Name

Physician's Signature

PLEASE RETURN TO THE SCHOOL HEALTH CHAIRMAN