

**SCHOOL TOWN OF MUNSTER
ELEMENTARY PHYSICAL EXAMINATION AND HEALTH INFORMATION**

STUDENT NAME _____ BIRTH DATE _____ M ____ F ____ ENTRY DATE _____
 ADDRESS _____ PHONE _____ SCHOOL _____ GRADE _____

MEDICAL HISTORY (to be completed by parent)

<input type="checkbox"/> CHICKEN POX	DATE:
<input type="checkbox"/> TB/ TB CONTACT	DATE :
<input type="checkbox"/> ADD/ADHD (diagnosed by MD)	(medication at school?)
<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> CONGENITAL DEFECT	
<input type="checkbox"/> DIABETES	
<input type="checkbox"/> EAR/ HEARING PROBLEMS	
<input type="checkbox"/> EYE / VISION PROBLEMS	
<input type="checkbox"/> FREQUENT HEADACHES	
<input type="checkbox"/> HEART PROBLEMS	
<input type="checkbox"/> SEIZURES (give type of seizure, medications and date of last seizure)	
<input type="checkbox"/> HOSPITALIZATIONS (list and give dates)	
<input type="checkbox"/> SURGERIES (list and give dates)	
<input type="checkbox"/> ALLERGIES (list all)	
<input type="checkbox"/> ROUTINE MEDICATIONS (list and give reason)	
<input type="checkbox"/> OTHER CONCERNS	

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL FOR HEALTH AND EDUCATION PURPOSES AS NEEDED.

PARENT SIGNATURE _____ DATE _____

STUDENT NAME _____

IMMUNIZATION RECORD (* required for attendance at school. Please provide exact dates for all immunizations.)

IMMUNIZATION	#1 (MO/DAY/YR)	#2 (MO/DAY/YR)	#3 (MO/DAY/YR)	#4 (MO/DAY/YR)	#5(MO/DAY/YR)
*Dtap, DPT					
*DT					
*Td					
Tdap (6 th grade)					
*IPV					
OPV					
*MMR					
*MEASLES					
*MUMPS					
*RUBELLA					
*VARICELLA					
*HEPATITIS B					

(not required for attendance at school)

HEPATITIS A					
HIB/HbOC					
PNEUMOCOCCAL					
MCV4 (6 th grade)					
OTHER (Please specify)					

Chicken Pox Disease: Date: _____ MD Verification _____

PLEASE SEE OTHER SIDE FOR PHYSICIAN EXAMINATION

STUDENT NAME: _____ BIRTHDATE _____

PHYSICAL EXAMINATION (to be completed by physician)

EVALUATION (REQUIRED) HEIGHT _____ WEIGHT _____ B/P _____	NORMAL	FOLLOW UP/ COMMENT	AS NEEDED	
			DATE	RESULT
SKIN			HGB/ HCT	
EYES			URINALYSIS	
EARS			LEAD SCREEN	
NOSE			SICKLE CELL	
THROAT				
DENTAL				
CARDIOVASCULAR				
RESPIRATORY				
GASTROINTESTINAL				
GENITO-URINARY				
NEUROLOGICAL				
MUSCULOSKELETAL				
SCOLIOSIS SCREEN				
NUTRITIONAL STATUS				
MENTAL HEALTH				
OTHER				

Please list any chronic illnesses, allergies, medications, diet restriction, special equipment and general comments _____

ON THE BASIS OF THIS EXAMINATION I APPROVE THIS CHILD'S PARTICIPATION IN (if no please attach explanation)

PHYSICAL EDUCATION: YES NO INTERSCHOLASTIC SPORTS: YES NO

PHYSICIAN'S NAME (please print)	PHYSICIAN'S SIGNATURE
ADDRESS	PHONE _____ DATE _____

(PLEASE FILL IN IMMUNIZATION RECORD ON REVERSE SIDE)

SCREENING PROCEDURES (To be completed by school nurse)

AUDIOMETRIC SCREENING

GRADE								
DATE								
FREQUENCY	R	L	R	L	R	L	R	L
6,000								
4,000								
3,000								
2,000								
1,000								
500								
REFERRAL/ FOLLOWUP								

20 DCB PASSING (25 DCB AT 500)

VISION SCREENING

GRADE								
DATE								
	R	L	R	L	R	L	R	L
FAR VISION								
NEAR VISION								
WITH GLASSES ON								
REFERRAL/ FOLLOW UP								