

**SCHOOL TOWN OF MUNSTER – High School and Middle School
PHYSICAL EXAMINATION AND HEALTH INFORMATION
(Required for 6th graders, 9th graders and students new to the school in other grades)**

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

MEDICAL HISTORY TO BE COMPLETED BY PARENT

Please check if the student has had the following (give details):

<input type="checkbox"/>	CHICKEN POX	Date (month/year):	
<input type="checkbox"/>	TB/ TB CONTACT	Date:	Details:
<input type="checkbox"/>	ADD/ADHD (diagnosed by MD)	(medication at school?)	Yes No Medication Name:
<input type="checkbox"/>	ASTHMA	mild moderate severe	
<input type="checkbox"/>	CONGENITAL DEFECT (details)		
<input type="checkbox"/>	DIABETES	Type I Type II	(contact school nurse before school entry)
<input type="checkbox"/>	EAR/ HEARING PROBLEMS		
<input type="checkbox"/>	EYE / VISION PROBLEMS	Wears glasses?	Wears contacts?
<input type="checkbox"/>	MIGRAINES (diagnosed by MD)		
<input type="checkbox"/>	FREQUENT HEADACHES (other than dr. diagnosed migraines)		
<input type="checkbox"/>	HEART PROBLEMS (details)		
<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, detail here and call nurse with any life threatening allergies)		
<input type="checkbox"/>	ROUTINE MEDICATIONS (list and give reason)		
<input type="checkbox"/>	INFECTIONS MONONUCLEOSIS	Date:	
<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 _____

(The section below is for School Nurse use only)

SCREENING PROCEDURES

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								

NURSE'S NOTES/COMMENTS

INFORMATION ON THIS SIDE OF THE PAGE IS TO BE PROVIDED AND SIGNED BY THE PHYSICIAN. ANY PHYSICALS DONE BY A **NURSE PRACTITIONER** MUST ALSO BE CO-SIGNED BY A PHYSICIAN. **PARENTS MUST FILL OUT THE MEDICAL HISTORY** PORTION ON THE REVERSE SIDE OF THIS FORM. **SPORTS PHYSICALS ARE A SEPARATE FORM AND MUST ALSO BE FILLED OUT IN FULL BY DOCTOR AND PARENT.**

STUDENT NAME: _____ BIRTHDATE _____

PHYSICAL EXAMINATION

HEIGHT	WEIGHT	B/P	VISION		Lab testing (recommended not required)			
			R	L		DATE	RESULT	
EVALUATION			NORMAL	COMMENTS				
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, explain below):

PHYSICAL EDUCATION: YES NO

PLEASE NOTE: THE IHSAA REQUIRES A SEPARATE PHYSICAL TO BE FILLED OUT FOR SPORTS PARTICIPATION. *Both School and Sports physicals need to be dated May 1 or later of the school year. Physicals done by Nurse Practitioners must be co-signed by physician.

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

IMMUNIZATION RECORD

* Required for admission to school. Varicella vaccine required if student has not had chicken pox disease. Please provide exact dates for all immunizations.

IMMUNIZATION	# of doses required ↓	#1 dose	#2 dose	#3 dose	#4 dose	#5 dose	#6 dose
*DPT	five doses						
*DT							
*Td							
*Tdap	one dose after age 10						
*IPV/OPV	four doses						
*MMR	2 doses of combo or ↓						
*MEASLES (2)							
*MUMPS (2)							
*RUBELLA (1)							
HEPATITIS A							
*HEPATITIS B	three doses						
HIB							
HPV (Gardasil)							
* MENINGITIS (MCV4)	one dose						
*VARICELLA	two doses or ↓						
CHICKEN POX (month/yr. of disease)							
TB SKIN TEST		RESULT:					

PHYSICIAN'S SIGNATURE	DATE
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