

**GREATER JASPER CONSOLIDATED SCHOOLS
JASPER, INDIANA**

**PHYSICAL EXAMINATION RECORD
(To be completed by your doctor)**

Name _____ Grade _____ School _____
Last First Middle

Address _____ Telephone _____

Date of birth _____ Sex _____ Family Physician _____
Month Day Year

PHYSICAL EXAMINATION

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

RECORD OF REQUIRED IMMUNIZATIONS

(Month-Day-Year)
**DPT (Diphtheria, 1. _____
or Pertussis 2. _____
DT Tetanus) 3. _____
4. _____
5. _____**

Measles/Mumps/Rubella (MMR)

1. _____ 2. _____

Oral Polio

1. _____
2. _____
3. _____
4. _____
5. _____

HIB

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

Hepatitis B

1. _____
2. _____
3. _____

Varicella (VZV)

1. _____
2. _____

Hepatitis A

1. _____ 2. _____

TESTS

Urinalysis: Date _____ Results _____
Hemoglobin: _____
Other: _____

PHYSICIAN'S RECOMMENDATIONS

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

Date _____ M.D.

Dental

Care Needed? Yes _____ No _____

Recommendations _____

Date _____ D.D.S.

PLEASE RETURN TO THE SCHOOL NURSE