

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. _____

TESTS

Tuberculin: Type _____ Date _____

Neg _____ Pos _____

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 ON REGISTRATION DAY