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, or Pertussis DT Tetanus)
1. ______________
2. ______________
3. ______________
4. ______________
5. ______________

Measles/Mumps/Rubella (MMR)
1. __________ 2. __________

Oral Polio
1. __________
2. __________
3. __________
4. __________
5. __________

HIB
1. __________
2. __________
3. __________
4. __________

Varicella (VZV)
1. __________
2. __________

Hepatitis B
1. __________
2. __________
3. __________

Hepatitis A (Optional)
1. __________ 2. __________

TESTS

Urinalysis: Date ________ Results __________

Hemoglobin: ______________________

Other: ______________________

____

PHYSICIAN'S RECOMMENDATIONS

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

______________________ ______________________ M.D.
Date

Dental

Care Needed? Yes __________ No __________

Recommendations ______________________________

____

______________________ ______________________ D.D.S.
Date

PLEASE RETURN TO THE SCHOOL NURSE