



HIGH SCHOOL AND MIDDLE SCHOOL

PHYSICAL EXAMINATION AND HEALTH INFORMATION

(Required for 6th & 8th graders and students new to the School Town of Munster in other grades)

Student Name: _____ Birthdate: _____ 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):

Chicken pox	Date: _____
TB/TB contact	Date: _____
ADD/ADHD (diagnosed by MD)	Medication at school No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, list medication name: _____
ASTHMA	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
Congenital Defect (details) _____	
Diabetes:	Type I <input type="checkbox"/> Type II <input type="checkbox"/> Please contact the school nurse before school entry)
Ear/Hearing Problems	
Eye/Vision Problems	Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/>
Migraines (diagnosed by MD)	
Frequent Headaches	
Heart Problems (details)	
Seizures (give type of seizure, medications, date of last seizure)	
Hospitalizations (list and provide dates)	
Surgeries (list and provide dates)	
Allergies (list here - contact nurse with any life-threatening allergies)	
Routine Medications (list and give reason)	
Infectious mononucleosis Date: _____	
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 to be completed by a Physician ONLY

Physician Name

Physician Signature

Address

Phone Number

Date

Immunization Record

Required for admission to school. Please provide exact dates for all immunizations.

Immunization	#1 Dose	#2 Dose	#3 Dose	#4 Dose	#5 Dose	#6 Dose
DTaP/DTP/Td						
Hep B						
Polio (IPV/OPV)						
Varicella (Chicken Pox)						
MMR (Measles, Mumps,						
Hep A						
MCV4 (Meningococcal)						
MenB (Meningococcal)						
Tdap						
Hib						
Pneumo (PCV)						

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.

Student Name: _____

Birthdate: _____

Physical Examination

Height:	Weight:	B/P:	Vision: R _____ L _____
Evaluation	Normal	Comments	Labs
Skin			Hgb/Hct Date: Result:
Eyes			Urinalysis Date: Result:
Ears			Lead Screen Date: Result:
Nose			Sickle Cell Date: Result:
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 Physical education:

Yes: No: (If no, please attach explanation):

Physician Signature

Date

Address: _____