SCHOOL TOWN of MUNSTER
A DISTRICT OF NATIONAL DISTINCTION
SUPPORTING EVERY CHILD EVERY DAY

ELEMENTARY PHYSICAL EXAMINATION AND HEALTH INFORMATION

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

MEDICAL HISTORY (to be completed by parent)

☐	CHICKEN POX DATE:
☐	TB/ TB CONTACT DATE :
☐	ADD/ADHD (diagnosed by MD) (medication at school?)
☐	ASTHMA
☐	CONGENITAL DEFECT
☐	DIABETES
☐	EAR/ HEARING PROBLEMS
☐	EYE / VISION PROBLEMS
☐	FREQUENT HEADACHES
☐	HEART PROBLEMS
☐	SEIZURES (give type of seizure, medications and date of last seizure)
☐	HOSPITALIZATIONS (list and give dates)
☐	SURGERIES (list and give dates)
☐	ALLERGIES (list all)
☐	ROUTINE MEDICATIONS (list and give reason)
☐	OTHER CONCERNS

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL FOR HEALTH AND EDUCATION PURPOSES AS NEEDED.

PARENT SIGNATURE _____ DATE_____

_____

STUDENT NAME _____

IMMUNIZATION RECORD **(* required for attendance at school. Please provide exact dates for all immunizations.)**

IMMUNIZATION	#1 (MO/DAY/YR)	#2 (MO/DAY/YR)	#3 (MO/DAY/YR)	#4 (MO/DAY/YR)	#5(MO/DAY/YR)
*Dtap, DPT					
*DT					
*Td					
Tdap (6th grade)					
*IPV					
OPV					
*MMR					
*MEASLES					
*MUMPS					
*RUBELLA					
*VARICELLA					
*HEPATITIS B					

* HEPATITIS A					
HIB/HbOC					
PNEUMOCOCCAL					
* MCV4 (6th grade)					
OTHER (Please specify)					

Chicken Pox Disease: Date:_____ MD Verification _____

PLEASE SEE OTHER SIDE FOR PHYSICIAN EXAMINATION

STUDENT NAME: _____ **BIRTHDATE** _____

PHYSICAL EXAMINATION (to be completed by physician)

EVALUATION (REQUIRED)	NORMAL	FOLLOW UP/ COMMENT	AS NEEDED		
HEIGHT_____ WEIGHT_____ B/P _____				DATE	RESULT
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 please attach explanation)

PHYSICAL EDUCATION: YES ☐ NO ☐ INTERSCHOLASTIC SPORTS: YES ☐ NO ☐

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

(PLEASE FILL IN IMMUNIZATION RECORD ON REVERSE SIDE)

School Nurse Notes:

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