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

HIGH SCHOOL AND MIDDLE SCHOOL
PHYSICAL EXAMINATION AND HEALTH INFORMATION

(Required for 6th & 9th 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 ☐ Yes ☐ If yes, list medication name:
	ASTHMA Mild ☐ Moderate ☐ Severe ☐
	Congenital Defect (details)
	Diabetes: Type I ☐ Type II ☐ Please contact the school nurse before school entry)
	Ear/Hearing Problems
	Eye/Vision Problems Wears glasses ☐ Wears contacts ☐
	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: _____