

**LOUISVILLE CITY SCHOOLS
PHYSICAL EXAMINATION**

Parent's fill in TOP PORTION ONLY

School: _____ Student's Name: _____ M _____ F _____

Date of Birth: _____ Parent's Name _____

Address: _____ Phone: _____

Immunizations Record-Dates (Must include Month, Day and Year) COMPLETED BY DOCTOR

	DOSE 1	DOSE 2	DOSE 3	DOSE 4	BOOSTER	PHYSICIAN'S ASSESSMENT	
Dtap * DT * Td						Height	Weight
Polio (OPV or IPV)						Nutrition	Skin
HIB						Eyes	Nose
MMR						Ears	Throat
Hepatitis B						Glands	Heart
Varicella						Lungs	Abdomen
Hepatitis A						History of Accidents:	
Pneum. Conj (PCV)							
Tuberculin							
Other							

Disease History - Dates Requested.

Mumps:	Rheumatic Fever:	Chickenpox:	Polio:
Tuberculosis:	Measles:	Scarlet Fever:	Whooping Cough:

Limiting Health Problems* (Please indicate all that apply and the year of diagnosis, if possible)

Accident - Serious		Neurological Disorder		Diabetes	
Allergy - drug/other		Orthopedic Handicap		Surgery - Serious	
Asthma		Hearing Loss		Hypertension	
Blood Disorder		Otitis Media		Kidney Disorder	
Seizure Disorder		Cardiac Disease/Problem		Urinary Problem	
Speech Disorder		Congenital Deformity		Muscular Problem	
Vision Disorder		Bowel Disorder		Other	

Describe* _____

Is this student able to participate in the required physical education program? Yes No

If not, what activities do you recommend? _____

_____ Physician's Signature

Date of Examination

DENTAL EXAMINATION

Teeth _____ Gums _____ Oral Hygiene _____

_____ Physician's Signature

Date of Examination

Upon completion, please return this form to your school. It is due by the first day of school.