

REITZ



MEMORIAL HIGH SCHOOL

1500 LINCOLN AVENUE • EVANSVILLE, INDIANA 47714-1595
PHONE 812-476-4973 • FAX 812-474-2942 • www.reitzmemorial.org

PHYSICAL EXAMINATION RECORD REQUIRED BY INDIANA STATE LAW IC 20-30-5-18 AND INDIANA CODE 410 IAC 1-1-1

(Required for all incoming freshmen and transfer students prior to the beginning of the school year, to be completed only by a physician)

NAME LAST FIRST MI DATE GRADE
ADDRESS TELEPHONE
DATE OF BIRTH MONTH / DAY / YEAR SEX PHYSICIAN

PHYSICAL EXAMINATION

(CODE: No Defect - 0; Defect - Note)

Height Weight
Eyes Vision (Snellen) Right Left Glasses Right Left
Ears: Right Left
Teeth Caries
Nose
Throat
Lymph Nodes
Thyroid
Heart
Blood Pressure
Lungs
Abdomen
Hernia
Orthopedic Impairments
Scoliosis Screening
Nutrition
Skin
Nervous Symptoms
Menstrual History
Ano-rectal
External Genitals
General Condition
History of severe illnesses, injuries or surgeries

RECORD OF REQUIRED IMMUNIZATIONS

(Circle abbreviation of Immunization administered)

DPT/DTaP 1-7
MMR 1-2
Varivax 1-2
Varicella 1-2
Chicken Pox Disease (Circle one) Yes No Date of Disease
Polio Vaccine OPV/IPV 1-6
Hepatitis B 1-3
HIB 1-3
Menactra 1 (Meningococcal Vaccine - MCV4 / MPSV4)
OTHER 1-3
HPV 1-3

TESTS

Tuberculin: Type Date Results: X-Ray
Lead Screen: Date Results
Sickle Cell Anemia: Yes No Results
Urinalysis: Date Results

ALLERGIES:

PHYSICIAN'S RECOMMENDATIONS

I recommend medical or dental attention to the following conditions:

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

Date Print Physician's Name Physician's Signature M.D.

**Allergies:**

**PAST HEALTH HISTORY**  
(To be completed by parent)

NAME \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_ Grade \_\_\_\_  
Last First Middle Mo./Day/Year M/F  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Number of Children in Family \_\_\_\_\_  
Name of Doctor \_\_\_\_\_ Name of Family Dentist \_\_\_\_\_

(Use the reverse side of this record, as needed, for additional notations)

**A. GENERAL HEALTH**

**E. DISEASES AND CONDITIONS**

(Date)

- 1. Eye symptoms \_\_\_\_\_  
Wears glasses \_\_\_\_\_  
Age when received glasses \_\_\_\_\_
- 2. Ear symptoms \_\_\_\_\_  
Hearing \_\_\_\_\_  
Earaches (Explain) \_\_\_\_\_  
Discharging ear \_\_\_\_\_
- 3. Colds, sore throat, etc. \_\_\_\_\_
- 4. High fever (Explain) \_\_\_\_\_
- 5. Fainting spells (Explain) \_\_\_\_\_
- 6. Convulsions (Date and cause) \_\_\_\_\_
- \_\_\_\_\_
- 7. Dental problems \_\_\_\_\_
- 8. Speech difficulty \_\_\_\_\_
- 9. Medications (Names) \_\_\_\_\_  
Are they taken regularly? \_\_\_\_\_  
When? \_\_\_\_\_
- 10. Diabetes \_\_\_\_\_  
Is there diabetes in family? \_\_\_\_\_  
Give relationship \_\_\_\_\_

- Whooping Cough
- Chickenpox
- Measles-Rubeola
- Rubella (3 day)
- Mumps
- Scarlet Fever
- Strep Throat
- Rheumatic Fever
- Mononucleosis
- Poliomyelitis
- Bronchitis
- Pneumonia

**DEVELOPMENT**

- 11. Tuberculosis contacts (When?)  
Who? \_\_\_\_\_

Normal Birth? Yes \_\_\_ No \_\_\_  
If not, explain Age of:

**B. OPERATIONS** (Explanation and dates)

**C. INJURIES** (Explanation and dates)

**D. OTHER:**

- First tooth \_\_\_\_\_ months
- Sitting \_\_\_\_\_ months
- Walking \_\_\_\_\_ months
- First words \_\_\_\_\_ months
- Sentences \_\_\_\_\_ months
- Toilet trained \_\_\_\_\_ months

Is there any condition present which should be considered in planning your child's program at school?

Date

Signature of parent or guardian

**PLEASE RETURN TO THE SCHOOL NURSE**

Reviewed 8/08