REITZ MEMORIAL HIGH SCHOOL
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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 _____ DATE _____ GRADE _____
LAST FIRST MI

ADDRESS _____ TELEPHONE _____

DATE OF BIRTH ____/____/____ SEX _____ PHYSICIAN _____
MONTH / DAY /YEAR

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 _____

Ongoing Medical Concerns: _____

RECORD OF REQUIRED IMMUNIZATIONS
(Circle abbreviation of Immunization administered)

DPT/DTaP 1. _____
DPT/DTaP 2. _____
DPT/DTaP 3. _____
DPT/DTaP 4. _____
DPT/DTaP 5. _____
DPT/DTaP 6. _____
DPT/DTaP 7. _____

Tdap 1. _____

Td Booster 1. _____
2. _____
3. _____

Polio Vaccine
OPV/IPV 1. _____
OPV/IPV 2. _____
OPV/IPV 3. _____
OPV/IPV 4. _____
OPV/IPV 5. _____
OPV/IPV 6. _____

Menactra 1. _____
(Meningococcal Vaccine - MCV4 / MPSV4)

OTHER
1. _____
2. _____

MMR 1. _____
2. _____
3. _____
4. _____

Varivax 1. _____
2. _____

Varicella 1. _____
2. _____

Chicken Pox Disease (Circle one)
Yes No
Date of Disease _____

Hepatitis B
1. _____
2. _____
3. _____

HIB 1. _____
2. _____
3. _____

HPV
1. _____
2. _____
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 _____

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

PLEASE RETURN TO THE SCHOOL HEALTH CHAIRMAN

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

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_____

DEVELOPMENT

11. Tuberculosis contacts (When?)
    Who?_____

B. OPERATIONS (Explanation and dates)

_____

C. INJURIES (Explanation and dates)

_____

D. OTHER:_____

_____

_____

E. DISEASES AND CONDITIONS

(Date)

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

Osgood-Schlatter
Epilepsy
Nose Bleeds
Asthma
Eczema

F. GROWTH AND

Normal Birth? Yes ___ No___
If not, explain Age of:

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