

Signature School
610 Main Street
Evansville, IN 47708-1618
Phone: 812-421-1820
Fax: 812-421-9189

Physical Examination Record
(To be filled out only by a physician)

Name _____ Date _____ Grade _____

Address _____ Phone No. _____

Date of Birth _____ Sex _____ Family Physician _____

PHYSICAL EXAMINATION

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

1. Height (in inches) _____ Weight _____
2. Eyes:
 - Vision (Snellen) Right _____
 - Left _____
 - Glasses Right _____
 - Left _____
3. Ears: Right _____
- Left _____
4. Teeth: _____ Caries _____
5. Nose _____
6. Throat _____
7. Lymph Nodes _____
8. Thyroid _____
9. Heart _____
10. Blood Pressure _____
11. Lungs _____
12. Abdomen _____
13. Hernia _____
14. Orthopedic Impairments _____
15. Scoliosis Screening _____
16. Nutrition _____
17. Skin _____
18. Nervous Symptoms _____
19. Menstrual History _____
20. Ano-rectal _____
21. External Genitals _____
22. General Condition _____
23. History of severe illnesses, injuries or surgeries: _____
24. Ongoing Medical Concerns: _____

Circle abbreviation of Immunization administered

RECORD OF REQUIRED IMMUNIZATIONS

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

- | | |
|---------------------|--------------------|
| Td Booster 1. _____ | Varicella 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | |
| 4. _____ | |

- | | |
|------------------|-------------|
| Polio Vaccine | Hepatitis B |
| OPV/IPV 1. _____ | 1. _____ |
| OPV/IPV 2. _____ | 2. _____ |
| OPV/IPV 3. _____ | 3. _____ |
| OPV/IPV 4. _____ | |
| OPV/IPV 5. _____ | HIB |
| OPV/IPV 6. _____ | 1. _____ |
| OPV/IPV 7. _____ | 2. _____ |

- Other
1. _____
 2. _____

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

Physicians's Recommendations

I recommend medical or dental attention to the following conditions: _____

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

Date _____ Print Physician's name _____ Signature of Physician _____

PLEASE RETURN TO THE SCHOOL