SCHOOL TOWN OF MUNSTER – High School and Middle School
PHYSICAL EXAMINATION AND HEALTH INFORMATION
(Required for 6th graders, 9th graders, and students new to the school in other grades)

STUDENT NAME _____ BIRTH DATE _____ 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 (month/year):
❑ TB/ TB CONTACT Date: Details:
❑ ADD/ADHD (diagnosed by MD) (medication at school?) (circle) YES NO Medication name:
❑ ASTHMA (circle) MILD MODERATE SEVERE
❑ CONGENITAL DEFECT (details)
❑ DIABETES (circle) Type I Type II (contact school nurse before school entry)
❑ EAR/ HEARING PROBLEMS
❑ EYE / VISION PROBLEMS Wears glasses? Wears contacts?
❑ MIGRAINES (diagnosed by MD)
❑ FREQUENT HEADACHES (other than dr. diagnosed migraines)
❑ HEART PROBLEMS (details)
❑ SEIZURES (give type of seizure, medications and date of last seizure)
❑ HOSPITALIZATIONS (list and give dates)
❑ SURGERIES (list and give dates)
❑ ALLERGIES (list all, detail here and call nurse with any life threatening allergies)
❑ ROUTINE MEDICATIONS (list and give reason)
❑ INFECTIONS, 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 for School Nurse only)

SCREENING PROCEDURES

AUDIOMETRIC SCREENING

GRADE								
DATE								
FREQUENCY	R	L	R	L	R	L	R	L
6,000								
4,000								
3,000								
2,000								
1,000								
500								
REFERRAL/ FOLLOWUP								

20 DCB PASSING (25 DCB AT 500)

VISION SCREENING

GRADE								
DATE								
	R	L	R	L	R	L	R	L
FAR VISION								
NEAR VISION								
WITH GLASSES ON								
REFERRAL/ FOLLOW UP								

NURSE'S NOTES/COMMENTS

PLEASE SEE OTHER SIDE FOR PHYSICIAN EXAMINATION

INFORMATION ON THIS SIDE OF THE PAGE IS TO BE PROVIDED BY 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** BY DOCTOR AND PARENT.

STUDENT NAME: _____ **BIRTHDATE** _____

PHYSICAL EXAMINATION

HEIGHT_____	**WEIGHT**_____	**B/P** _____	**Vision R** _____ **L** _____

EVALUATION	**NORMAL**	**COMMENTS**
SKIN		
EYES		
EARS		
NOSE		
THROAT		
DENTAL		
CARDIOVASCULAR		
RESPIRATORY		
GASTROINTESTINAL		
GENITO-URINARY		
NEUROLOGICAL		
MUSCULOSKELETAL		
SCOLIOSIS SCREEN		
NUTRITIONAL STATUS		
MENTAL HEALTH		
OTHER		

Lab testing (recommended, not required)	DATE	RESULT
HGB/ HCT		
URINALYSIS		
LEAD SCREEN		
SICKLE CELL		

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 (if no, please attach explanation):
PHYSICAL EDUCATION: YES☐ NO ☐

_____

_____

PLEASE NOTE: THE IHSAA REQUIRES A SEPARATE PHYSICAL TO BE FILLED OUT FOR SPORTS PARTICIPATION FOR HIGH SCHOOL STUDENTS. *Both School and Sports physicals need to be dated April 1 or later of the school year.
Physicals done by Nurse Practitioners must be co-signed by a physician.

PHYSICIAN'S NAME (please print)	**PHYSICIAN'S SIGNATURE**	
ADDRESS	**PHONE**	**DATE**

IMMUNIZATION RECORD

*** Required for admission to school. Varicella vaccine required if student has not had chicken pox disease. Please provide exact dates for all immunizations.**

IMMUNIZATION # of doses required	#1 dose	#2 dose	#3 dose	#4 dose	#5 dose	#6 dose
*DPT						
*DT five doses						
*Td						
Tdap one dose after age 10						
*IPV/ OPV four doses						
*MMR two doses of combo or ↓						
*MEASLES (2)						
* MUMPS (2)						
* RUBELLA (1)						
HEPATITIS A						
*HEPATITIS B three doses						
HIB						
HPV (Gardasil)						
* MENINGITIS (MCV4) one dose , **if grade 12 - two doses**						
* VARICELLA two doses or ↓						
CHICKEN POX (month/year of disease)						
TB SKIN TEST	Date:		Result:			

PHYSICIAN'S SIGNATURE	DATE