THIS MUST BE RETURNED TO THE MAIN OFFICE BY FRIDAY, AUGUST 7, 2020

MATER DEI HIGH SCHOOL
HEALTH DEPARTMENT - NURSING DIVISION - Evansville, Indiana

PHYSICAL EXAMINATION RECORD

(To be completed by your doctor)

NAME______________________________________GRADE__________ TEACHER______________________________
(Last) (First) (Middle)
ADDRESS__________________________________CITY______________TELEPHONE # _____ - _____ - ______
DATE OF BIRTH________/ _________ / _________ SEX _____________ FAMILY PHYSICIAN ________________
PHYSICIAN PHONE #________________
ALLERGIES ____
____

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

Height_________ Weight________

Eyes (indicate if with/without glasses/contacts)
Vision (Snellen) Right:_________
Left:__________

Ears: Right: _________
Left:__________

Teeth ________________________
Caries________________________
Nose_________________________
Throat________________________
Lymph Nodes__________________
Thyroid_______________________
Heart ________________________
Blood Pressure ________________
Lungs________________________
Abdomen______________________
Hernia________________________
Orthopedic Impairments
____
Posture/Scoliosis _______________
Nutrition______________________
Skin _________________________
Nervous Symptoms______________
Menstrual History ______________
Anno-rectal____________________
External Genitals_______________
General Condition ______________
History of severe illnesses, injuries, or surgeries______________________

FULL RECORD OF REQUIRED IMMUNIZATIONS
Month/Day/Year

DPT/DTap 1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

Td 1. ____________
2. ____________

Tdap 1. ____________

Polio Vaccine (circle type)
OPV/IPV 1. ____________
OPV/IPV 2. ____________
OPV/IPV 3. ____________
OPV/IPV 4. ____________
OPV/IPV 5. ____________
OPV/IPV 6. ____________

Meningococcal 1. _________
MCV4 / MPSV4 (circle type)

HPV 1. ____________
2. ____________
3. ____________

Other________________
1. ____________
2. ____________

MMR 1. ____________
2. ____________
3. ____________

Hepatitis A
1. ____________
2. ____________

Hepatitis B
1. ____________
2. ____________
3. ____________

HIB 1. ____________
2. ____________
3. ____________
4. ____________

Prevnar 1. ____________
2. ____________
3. ____________
4. ____________

Varicella
1. ____________
2. ____________
or
Date of Disease
____

****

TESTS A) Tuberculin: Type________ Date_______ Negative____Positive_____________X-Ray__________
B) Lead Poisoning: Yes_____ No_______ Results_______________________________________
C) Urinalysis: Date_________________Results____
D) Other ____

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______________________ Signature of Physician________________________ MD
Printed name of Physician________________________ MD

 PLEASE RETURN TO THE MAIN OFFICE AT MATER DEI (NOT TO THE ATHLETIC DEPT)

(OVER)

MATER DEI HIGH SCHOOL

HEALTH DEPARTMENT - NURSING DIVISION
Evansville, Indiana

PAST HEALTH HISTORY

(To be completed by parent)

NAME____ Birth Date______I_____I__________
Last First Middle Mo./ Day / Year

Grade ___________Sex __________

Address____ ______Telephone_______________________

Number of Children in Family_________ Name of Family Doctor ______________________ Name of Family Dentist_____________________________

ALLERGIES____
____
____

A. GENERAL HEALTH (Chicken pox date required if not vaccinated)
(Use the reverse side of this record, as needed, for additional notations)

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__________________________
11. Tuberculosis contacts (When?)_______________

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	______
Hepatitis	______
Osgoode-Schlatter	______
Epilepsy	______
Nose Bleeds	______
Asthma	______
Eczema	______

F. GROWTH AND DEVELOPMENT

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 MAIN OFFICE AT MATER DEI
(NOT THE ATHLETIC OFFICE-THAT IS A DIFFERENT FORM)