THIS MUST BE RETURNED TO THE MAIN OFFICE BY FRIDAY, AUGUST 9, 2021

MATER DEl 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

Jan-18 **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_____

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1/21