THIS MUST BE RETURNED TO THE MAIN OFFICE BY WEDNESDAY AUGUST 1, 2019

MATER DEI HIGH SCHOOL

HEALTH DEPARTMENT– NURSING DIVISION-Evansville, IN

PHYSICAL EXAMINATION RECORD

(To be completed by your doctor)

NAME_____ GRADE_____

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)
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 (circle type)
MCV4/MPSV4 1. _____
MCV4/MPSV4 2. _____

HPV 1._____
2._____

MMR 1._____
2._____

Hepatitas A 1._____
2. _____

Hepatitas B 1._____
2._____
3._____

Hib 1._____
2._____
3._____
4._____

Prevnar 1._____
2._____
3._____
4._____

Varicella 1._____
2._____
(or date of disease)_____

Other 1._____
2._____

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_____ Printed Name of Physician_____

(Over)

PLEASE RETURN TO THE MAIN OFFICE (NOT THE ATHLETIC DEPT)

MATER DEI HIGH SCHOOL

HEALTH DEPARTMENT– NURSING DIVISION-Evansville, IN

PAST HEALTH HISTORY

(To be completed by parent)

NAME_____ BIRTH DATE_______________
GRADE_____ SEX_____
ADDRESS_____CITY_____TELEPHONE#_____-_____-_____
NUMBER OF CHILDREN IN FAMILY_____ FAMILY PHYSICIAN NAME_____
FAMILY DENTIST NAME _____
ALLERGIES_____
_____

A. GENERAL HEALTH

Height_____Weight_____

1. Eye symptoms_____
   Wears glasses/contacts Yes_____ No_____
   Age when received glasses_____
2. Ear symptoms_____
   Hearing_____
   Earraches _____
   Dishcharging ear_____
3. Colds, sore throat, etc_____
4. High fever_____
5. Fainting spells_____
6. Convulsions_____
7. Dental Problems_____ _____
8. Speech difficulty_____
9. Medications (names)_____
   Are they taken regulary?_____
   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. DISEASE AND CONDITIONS (Date)

(Chicken pox date required if not vaccinated)

Whooping Cough	_____
Chicken pox	_____
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 no, 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/Guardian_____

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(NOT THE ATHLETIC OFFICE-THAT IS A DIFFERENT FORM)