Evansville Vanderburgh School Corporation

Bringing Learning to Life

To Parents/Guardians:

The Office of Health Services and Wellness of the Evansville Vanderburgh School Corporation highly recommends that every child have at least three physical examinations during his or her school career. One examination should be given at the time the child first enters school, most often this is upon entering Kindergarten. Students transferring from other school systems at any grade level should also have a physical examination or a report of a recent physical examination. The other grade levels where physical examinations are recommended are at the beginning of sixth grade and at the beginning of ninth grade.

We ask you to take the "Physical Examination Record" (Form #75.880), included with this letter, to your physician and return it to the school nurse on the first day of school. The record of immunizations is to be completed by a physician and returned with the examination record. *For students who plan to participate on a high school athletic team during the school year, the Indiana High School Athletic Association (IHSAA) form must also be completed by the physician and the parent after April 1st. It is helpful to schedule this examination during the summer to avoid the last minute rush in August.*

Beginning in 2010, Indiana Code requires that immunization records be entered into the State Immunization Registry (CHIRP) for all Indiana students. A parental consent to release your child's shot record to this Registry may also be attached: ***If*** *this form is attached and you give consent, please sign and return it also.*

If it is necessary for this student to be excused from physical education, please contact the school nurse for the appropriate form to be completed by the physician.

If you are financially unable to take your child to the doctor, please be aware that there are agencies available that can provide services on a sliding-fee-scale, based on your income. Please contact your school nurse for information.

Sincerely,

School Nurse

75.870

Rev. 2004, 2007, 2010, 2013, 2014, 2016

Evansville Vanderburgh School Corporation

Center for Family, School, and Community Partnerships
123 Main Street, Evansville, Indiana 47708 Phone (812) 435-8866 Fax (812) 435-8604
www.evscschools.com

I, _____, give _____ permission
(Parent/Guardian Name) *(Name of School)*

to release the following information concerning my child, _____,
(Name of Child)

_____, _____, to the Indiana State Department of Health's **C**hildren and
(Date of Birth) *(Grade Level)*

Hoosiers Immunization **R**egistry **P**rogram (**CHIRP**):

CHILD'S NAME, DATE OF BIRTH, ADDRESS, ETHNICITY and IMMUNIZATION DATA

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Parent Signature ***Date***

_____ (____)_____
Home Address ***Telephone Number***

PLEASE RETURN COMPLETED / SIGNED FORM TO SCHOOL NURSE

Form 75.880
Rev. 05/00, 09/05, 08/07,04/10

EVSC
Evansville Vanderburgh School Corporation

OFFICE OF HEALTH SERVICES & WELLNESS

Home Room Teacher _____

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

Name _____ Grade _____ Date _____

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 _____
   Hearing: 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. _____
DPT/DTaP 2. _____
DPT/DTaP 3. _____
DPT/DTaP 4. _____
DPT/DTaP 5. _____
DPT/DTaP 6. _____

Td 1. _____
2. _____

Tdap 1. _____

Polio Vaccine
OPV/ IPV 1. _____
OPV/ IPV 2. _____
OPV/ IPV 3. _____
OPV/ IPV 4. _____
OPV/ IPV 5. _____
OPV/ IPV 6. _____

Meningococcal 1. _____
MCV4 / MPSV4

Other 1. _____
2. _____

MMR 1. _____
2. _____

Hepatitis B
1. _____
2. _____
3. _____

HIB 1. _____
2. _____
3. _____
4. _____

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

Varicella
1. _____
2. _____
**Wild Disease*: _____

HPV 1. _____
2. _____
3. _____

TESTS

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

Physician'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 NURSE