



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



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. _____ MMR 1. _____

DPT/DTaP 2. _____ 2. _____

DPT/DTaP 3. _____ 3. _____

DPT/DTaP 4. _____

DPT/DTaP 5. _____ Hepatitis B

DPT/DTaP 6. _____ 1. _____

Td 1. _____ 2. _____ 3. _____

Tdap 1. _____ HIB 1. _____

2. _____ 2. _____

Polio Vaccine 4. _____

OPV/ IPV 1. _____

OPV/ IPV 2. _____ Pevnar1. _____

OPV/ IPV 3. _____ 2. _____

OPV/ IPV 4. _____ 3. _____

OPV/ IPV 5. _____ 4. _____

OPV/ IPV 6. _____

Meningococcal 1. _____ Varicella 1. _____

MCV4 / MPSV4 2. _____ 2. _____

Hep A 1. _____ HPV 1. _____

2. _____ 2. _____

Other 1. _____ 3. _____

2. _____

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 _____