WARRICK COUNTY SCHOOL CORPORATION
PHYSICAL EXAMINATION RECORD
(REVISED 03/2008)

SCHOOL: _____

PERIODIC PHYSICAL EXAMINATIONS BY A PHYSICIAN ARE IN THE BEST INTEREST OF EACH STUDENT AND ARE RECOMMENDED BY THE WARRICK COUNTY SCHOOL CORPORATION. STATE LAW REQUIRES THAT STUDENTS HAVE VERIFICATION OF THE REQUIRED IMMUNIZATIONS LISTED BELOW.

STUDENT _____ **DATE** _____

ADDRESS _____ **PHONE** _____

DATE OF BIRTH _____ **PLACE** _____ **SEX** _____ **GRADE** _____

1. **Height (inches)** _____ **Weight** _____ **Allergies** _____
2. **Eye Inspection:**
   With Glasses: R.E. _____ **Vision 20/** _____ **L.E.** _____ **Vision 20/** _____
   W/Out Glasses: R.E. _____ **Vision 20/** _____ **L.E.** _____ **Vision 20/** _____
   Squint _____
3. **Teeth: O.K.** _____ **Caries** _____ **Gums** _____
4. **Ears:**
   Right-Discharge _____ **Hearing Normal** _____ **Dull** _____
   Left-Discharge _____ **Hearing Normal** _____ **Dull** _____
5. **Nose** _____
6. **Throat** _____
7. **Lymph nodes** _____
8. **Thyroid** _____ **Other Glands** _____
9. **Heart** _____ **Blood Pressure** _____
10. **Lungs** _____
11. **Abdomen** _____
12. **Hernia** _____
13. **Orthopedic impairments** _____
14. **Posture** _____
15. **Nutrition** _____
16. **Skin** _____
17. **Nervous symptoms** _____
18. **Genitals** _____
19. **Ano-rectal** _____
20. **History of severe illnesses, operations, or accidents** _____
_____
21. **Urinalysis** _____
22. **General conditions** _____

IMMUNIZATIONS

Diphtheria-Tetanus-Pertussis (DPT , DT, Dtap)	**#1**	**#2**	**#3**	**#4**	**#5**
Polio - Specify (OPV or IPV)	**#1**	**#2**	**#3**	**#4**	
Prevnar	**#1**	**#2**	**#3**	**#4**	
HIB	**#1**	**#2**	**#3**	**#4**	
Gardisil	**#1**	**#2**	**#3**		
Rota Teq	**#1**	**#2**	**#3**		
Hepatitis B	**#1**	**#2**	**#3**		
Hepatitis A	**#1**	**#2**			
MMR	**#1**	**#2**			
Varivax	**#1**	**#2**			
Menactra	**#1**				
Tdap	**#1**				

Tuberculosis Test: Date: _____ **Kind:** _____ **Positive:** _____ **Negative:** _____
Sickle Cell Anemia _____ **At what age:** _____ **Positive:** _____ **Negative:** _____
Lead Poison _____ **At what age:** _____ **Positive:** _____ **Negative:** _____

PHYSICIAN'S RECOMMENDATIONS:
I RECOMMEND MEDICAL OR DENTAL ATTENTION FOR THE FOLLOWING CONDITIONS:
_____
_____

Student physically fit to participate in physical education: YES _____ **NO** _____

_____
(PHYSICIAN'S SIGNATURE) **(DATE)**