

INDIANOLA COMMUNITY SCHOOLS

Physical Examination Form

Grade _____

Name _____ Birth Date _____ Birth County/State _____

Address _____

Parent/Guardian _____ Home Phone _____ Work Phone _____

Family Physician _____ Hospital Preference _____

PERSONAL HISTORY TO FILL OUT BY PARENT BEFORE PHYSICAL EXAMINATION.

WRITE YES OR NO IN THE SPACE PROVIDED.

- 1. Asthma _____ 2. Allergies _____
- 3. Under a physician's care now _____
- 4. Taking medication now _____
- 5. Dental check-up within past year _____
- 6. Professional eye examination within past year _____
Wears glasses _____ Contact lens _____
- 7. Has had a communicable disease within past year _____
- 8. Date of last tetanus booster _____ polio _____ other _____
- 9. Injury requiring hospitalization or surgery during past three (3) years _____

EXPLAIN YES ANSWERS BELOW

Signature of Parent or Guardian _____

PHYSICAL EXAMINATION TO BE FILLED OUT BY PHYSICIAN

Height _____ Weight _____ Is weight appropriate for this student? _____

Eyes _____ Ears _____ Liver _____ Spleen _____ Hernia _____

Feet _____ Cardiovascular _____ Blood Pressure _____

Heart (before exercise) _____ (after exercise) _____

Laboratory: Urinalysis _____ Other _____

Respiratory _____ Neurological _____ Musculoskeletal _____

Complete Immunizations: Polio _____ (date) Tetanus _____ (date)
Other _____ (date)

Are all immunizations up to date? _____

TB test, if given: Kind _____ Date _____

Results: (Please circle) Negative Positive

Significant past history _____

I hereby certify that the above named student was examined by me and found physically fit to engage in all activities of the Indianola Community Schools except those activities that I have listed above.

Date of Examination _____ Signature of Physician _____