Form 75.880
Rev. 05/00, 09/05, 08/07, 3/13, 8/14, 7/17

Evansville Vanderburgh School Corporation
Bringing Learning to Life

OFFICE OF HEALTH SERVICES & WELLNESS

Home Room Teacher_____

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

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: _____
_____
_____
25. Allergies_____
_____

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._____
2._____

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

Meningococcal 1._____
MCV4 / MPSV4 2_____

Men B 1._____
2._____

Hep A 1._____
2._____

MMR 1._____
2._____
3._____

Hepatitis B
1._____
2._____
3._____

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

Prevnar1._____
2._____
3._____
4._____

Varicella
1._____
2._____

HPV 1._____
2._____
3._____

Other 1._____
2._____

TESTS (*Record results if applicable*):

Tuberculin: Type_____Date_____
Results:_____X-Ray_____
Lead Screen : Date_____Results_____
Sickle Cell Anemia: Yes_____No____Results_____
Urinalysis: Date_____Results_____

Medical Provider's Recommendations

I recommend medical or dental attention to the following conditions: _____
_____

Student physically fit to participate in physical education? Yes _____ No _____

_____ _____
Date Print Medical Provider's Name Signature of Medical Provider

PLEASE RETURN TO THE SCHOOL NURSE