ELEMENTARY AND HIGH SCHOOL PHYSICAL EXAMINATION FORM
(FORMULARIO DE EXAMEN FISICO)

ELKHART COMMUNITY SCHOOLS

STUDENT SERVICES DEPARTMENT

School (Escuela)______________________________Grade (Grado)_____Room (Salón)______Date (Fecha)___________

HEALTH INFORMATION: TO BE FILLED OUT BY PARENT OR GUARDIAN
(INFORMACION DE SALUD PARA SER COMPLETADA POR PADRE O GUARDIAN)

Name
(Nombre)____ Birthdate (Fecha de Nacimiento)_________________________________

Parent of Guardian
(Padre o Guardián)____ Telephone (Teléfono)____

Address (Dirección)____

Parent: If student has any of the following conditions, explain briefly:

(Padres: Si el estudiante presenta alguno de los siguientes estados de salud, explique brevemente:)

Allergies: specify (Alergias: explique)____
Asthma (Asma)____
Diabetes (Diabetes)____
Hay Fever (Fiebre del Heno)____
Headaches/Migraines (Dolores de Cabeza/Migraña)____
Hearing Loss (Pérdida del Oido)____
Hemophilia (Hemofilia)____
Rheumatic Fever (Fiebre Reumática)____
Speech Disorder (Trastorno del Habla)____
Seizure Disorder (Ataques)____
Visually Impaired (Vista dañada)____
Other (Otros)____

Takes Medication Regularly? If so, name these____
(Toma medicamentos regularmente?___Si es así, póngalos aquí)____

Have there been any serious illnesses, accidents, or surgeries that may have caused any impairment? No___Yes___If yes, what?
(Ha tenido alguna enfermedad seria, accidente, o cirugías que le hayan causado daño? No___Sí___En caso afirmativo, ¿qué?)

____

I give examining physician permission to immunize as requested by Elkhart Community Schools.
(Yo le doy permiso al médico para que le ponga las vacunas que requieren las Escuelas de la Comunidad de Elkhart.)

____
Signature of Parent or Guardian
(Firma del Padre o Guardián)

<u>Immunizations below to be attached or filled out by doctor's office. Please give month, day and year for each:</u>

Type of vaccine	Date given					
DTP/DtaP	___________	___________	___________	___________	___________	___________
Tdap	___________	___________				
Td	___________	___________	___________			
Hep A	___________	___________	___________			
Hep B	___________	___________	___________			
HIB	___________	___________	___________	___________		
HPV	___________	___________	___________			
IPV	___________	___________	___________	___________	___________	___________
OPV	___________	___________	___________	___________	___________	___________
MCV	___________	___________	___________			
MMR	___________	___________				
PCV	___________	___________	___________	___________		
BCG	___________	___________				
Varicella	___________	___________	Had varicella disease (indicate age or month/yr.) ___________			

Student's name (print) ____ Birth date ______________________
Visual acuity R_______L_________w/o correction Hearing (gross) ____________________________
Visual acuity R_______L_________w/correction Audiometry _______________________________
Wears glasses or contacts (circle) yes no Tympanometry_____________________________
Referred to eye specialist (circle) yes no Height___________Weight________BMI_______
Blood pressure __________________Pulse_____ Respiration ______ Peak flow ________ SaO2 _________ %

Lab test results

Hbg__________ Hct__________Lead ________ Sickle cell (circle) absent trait present not tested
Urinalysis: glucose_______ Bilirubin _______ Ketones _______ S/G ________ Blood _______ pH _________
Protein ______ Urobilinogen ______ Nitrite _______ Leukocytes ______ Color _________________________
Microscopic results ______________________________________T.B. test (circle) no yes results _____mm

Appearance ____

Head ____

Ears ____

Eyes ____

Nose ____

Throat ____

Mouth____

Teeth ____

Neck ____

Chest ____

Cardiac ____

Peripheral Vascular ____

Respiratory ____

Abdomen ____

Genitalia ____

Lymphatic ____

Musculoskeletal ____

Scoliosis ____

Neurologic ____

Physically fit to participate in physical education program? (circle) yes no
Physically fit to participate in competitive sports? (circle) yes no
Activity restrictions? ______________________________ Duration? _____________________________ none

(Doctor's note is required for any activity restrictions stating restriction and duration)

Date of exam _______________ Physician's signature ____
Office phone _______________ Printed physician's name ____