SCHOOL TOWN OF HIGHLAND
HEALTH SERVICES
PHYSICAL FORM

The information requested is necessary in order to better protect the health of the student. We appreciate you filling it out as accurately as possible.

School__________________________ **Grade**__________________
Student's Name____________________ **Birth date**_______________
Father's name_____________________ **Mother's Name**___________
Homes Address____________________ **Telephone**_______________

- Emergency Name and Number of someone who will assume the responsibility for the student if you are not available.

Name________________ **Relationship**______________ **Telephone**________________

CHECK THE CONDITIONS THAT PERTAIN TO YOUR STUDENT (give year)

Chicken pox______________
Rheumatic Fever___________
Scarlet Fever_____________
Mumps__________________
Measles_________________
Frequent Colds____________
Ear Infections____________
Diabetes_________________
Asthma__________________
Allergies (type) ___________
Epilepsy/Seizures _________
Hearing Problems__________
Vision Problems___________
Anxiety/Depression________
Kidney/ Bladder Problems_____
Blood Disease_____________
Orthopedic Problems________
Frequent Headaches________
Dental Problems___________
Gastrointestinal Problems_____
Skin Problems_____________
Dizziness/ Fainting_________

Is the student on medication? If so, please list.

Will the student be taking the medication at school?

What operations/ hospitalizations/ significant injuries, if any, has the student had? Please list dates.

Have the students eyes been examined by a doctor?

Does the student wear contacts or glasses?

Has the student been diagnosed with ADD/ADHD?
If yes, is the student on medication?

Do you have any concerns about your child's general health? (eating, sleeping habits, weight, teeth, etc.)?

***If necessary, please feel free to contact the school nurse for a confidential conference. ***

2019-2020 School Year
Indiana State Department of Health School Immunization Requirements

	3-5 Years	K	1	2	3	4	5	6	7	8	9	10	11	12
DTaP/TD DTP/Td*	4	5	5	5	5	5	5	5	5	5	5	5	5	5
Polio**	3	4***	4	4	4	4	4	4	4	4	4	4	4	4
Measles	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Mumps	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Rubella	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Hepatitis A	-	2	2	2	2	2	2	2	2	2	2	2	2	2
Hepatitis B	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Varicella ∞	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Tdap&MCV4	-	-	-	-	-	-	-	1	1	1	1	1	1	1

- *Four doses of DtaP/DTP/DT are acceptable if 4th dose was administered on or after child's fourth birthday

- **Three doses of polio vaccine are acceptable if 3rd dose was administered on or after child's fourth birthday **and** the doses are all IPV or all OPV
- ***The 4th dose of polio vaccine must be administered on or after child's fourth birthday.
- ∞Physician documentation of disease history, including month and year, is proof of immunity for preschool, kindergarten -6th. A signed statement from parent indicating history of disease indicating month and year is required for children in grades 7 -12.

PHYSICAL EXAMINATION RECORD (to be filled out by doctor)

Check if normal or abnormal. If abnormal, please describe below.

	NORMAL	ABNORMAL
Physical Development	☐	☐
Nutritional Development	☐	☐
Skin	☐	☐
Hair and Scalp	☐	☐
Eyes (except vision)	☐	☐
Ears (except hearing)	☐	☐
Nose	☐	☐
Throat	☐	☐
Lungs	☐	☐
Heart (heart rate_______bpm)	☐	☐
Abdomen	☐	☐
Extremities	☐	☐
Orthopedic	☐	☐

Describe if abnormal: also any other defect not listed: ______________________________

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PHYSICAL FITNESS EVALUATION

Please check one of these recommendations:

I recommend the regular school program ☐
(Physical Education includes running, basketball, tennis, ect.)

I recommend modified activity (specify degree and reasons ☐ ______________________

I recommend exclusion from Physical Education Class
REASON MUST BE GIVEN ☐ ______________________

COMMENTS AND RECOMMENDATIONS____

(Recommendations for modified activity or exclusion are effective for the current school year only)

IMMUNIZATIONS (To be filled out by the doctor, insert month, day, and year)

	1st	2nd	3rd	4th	5th
DTP/DtaP/ DT					
POLIO					
MMR					
HEPATITIS B					
HIB					
CHICKEN POX					
HEPATITIS A					

Signature of Physician______________________________ **Office Phone Number**________________

Date__________________

Revised 02/18