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
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____

____
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 _____________________ Musculoskelatal __________________
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 ____
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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** ________________________________