



755-3655 / 755-3656 / 755-3657

Susan W. Best, D.O.
Health Officer

Physical Examination For School Enrollment

School _____ Return by _____
Name _____ Gender _____ Birthdate _____
Address _____ City, State, Zip _____

MEDICAL HISTORY

	<u>Circle One</u>	<u>Year</u>		<u>Circle One</u>	<u>Year</u>
<u>Convulsions or Epilepsy</u>	No	Yes	_____	<u>Allergy</u>	No Yes
<u>Asthma</u>	No	Yes	_____	<u>Diabetes</u>	No Yes

If history of chickenpox please give month and year of disease, along with parent signature.

Month / Year _____ Parent Signature _____
Physicians Signature(Required for K-6th grade) _____

IMMUNIZATION HISTORY

Indiana Code 20-8.1-7-9.5 requires that all students enrolled in school have a written statement of his/her immunizations on file. Rules change, (410 IAC 1-1-1) states that all students have the following immunizations:

MUST LIST MONTH, DAY AND YEAR IMMUNIZATION

DTAP/DT/TD	1. _____	2. _____	3. _____	4. _____	5. _____
POLIO	1. _____	2. _____	3. _____	4. _____	5. _____
HEP B	1. _____	2. _____	3. _____	4. _____	
MMR	1. _____	2. _____			
VARIVAX	1. _____	2. _____			
HEP A	1. _____	2. _____			

(REQUIRED FOR KINDERGARTEN-
RECOMMENDED FOR ALL OTHER GRADES)

Immunizations may be received Monday through Thursday, 9:00 AM to 4:00 PM.

Call 755-3658 for additional information. YOU MUST BRING IMMUNIZATION RECORD

PHYSICIAN'S EXAMINATION

PHYSICAL and NUTRITIONAL DEVELOPMENT _____

HT. _____ WT. _____ NOSE _____ THROAT _____ CHEST _____ ABDOMEN _____

EXTREMITIES _____ MENTAL AND NUTRITIONAL DEVELOPMENT _____

PHYSICAL EDUCATION: NOT RESTRICTED _____ RESTRICTED _____

REASON _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____