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. ***

2020-2021 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

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- *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: _____
_____

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_____