PLYMOUTH COMMUNITY SCHOOL CORPORATION

HEALTH SERVICES DEPARTMENT - PHYSICAL EXAMINATION

Name _____ ☐ M ☐ F DOB _____ Grade _____
Last First M

Parents _____ Phone _____

Address _____ School _____

I give consent for my child to compete in the school's athletic program ☐ Y ☐ N

(Must have a signature before student can participate in sports) _____
Parent's Signature

MEDICAL HISTORY

☐ ADHD	☐ Headaches	☐ Nosebleeds	☐ Rubella	☐ Serious Injuries
☐ Allergies	☐ Heart	☐ Orthopedic Problems	☐ Scarlet Fever	_____
☐ Asthma	☐ Hepatitis	☐ Pneumonia	☐ Seizures	☐ Hospitalizations
☐ Cerebral Palsy	☐ Measles	☐ Pregnancy	☐ Sickle Cell Anemia	_____
☐ Chicken Pox	☐ Menstrual Cramps	☐ Rheumatic Fever	☐ Strep Infection	☐ Other _____
☐ Diabetes	☐ Mononucleosis	☐ RSV	☐ Surgeries	_____
☐ Ear Infections	☐ Mumps			_____

PHYSICIAN'S EXAMINATION

Height _____ **Weight** _____ **Temp** _____

Blood Pressure _____ **Pulse** _____

Posture _____

Nutrition _____ **Dentition** _____

Nose _____

Throat _____

Glands _____

Abdomen _____

Hernia _____

Scoliosis _____

Skin _____

Eyes _____

Vision R_____ L_____

Ears _____

Hearing (Gross) _____

Heart _____

Lungs _____

Orthopedic _____

Reflexes _____

Urinalysis _____

Physically fit to participate in the physical education program? ☐ Y ☐ N

Medications (name, dosage, reason): _____

_____

_____

_____

Physically fit for competitive sports? ☐ Y ☐ N

Reason for restricted program: _____

_____

Physician's Name _____ Physician's Signature _____ Date _____
please print

Plymouth Community School Corporation
School Entrance Health Form

To be completed by physician, registered nurse, or health department official.

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ *Last* *First* *Middle*				Date of Birth: ___/___/___ *Mo.* *Day* *Yr.*	
IMMUNIZATION	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN**				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td(given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children<2 years of age	1	2	3	4	
*Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1	2	Serological Confirmation of Measles Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV)	1	2	3	4	
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
*Hepatitis A Vaccine	1	2			
*Meningococcal Vaccine	1				
*Human Papillomavirus Vaccine	1	2	3		
*Other	1	2	3	4	5
*Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care, or preschool prescribed by the State Board of Health's Regulations for the Immunization of School Children.

Signature of Medical Provider or Health Department Official _____

Date (Mo., Day, Yr.): ___/___/___