INDIANA SCHOOL FOR THE DEAF
General Medical Examination

Student's Full Name: _____ Birth date: _____/_____/_____
Sex: Male □ Female □ Race:_____ Grade:_____
Parent/Guardian's Name:_____
Address: _____
City/State/Zip Code: _____
Home Phone Number: (____)_____VP #_____
Insurance Company: _____ Insurance Policy #:_____

IMMUNIZATION RECORD

DPT/DT Td or Tdap						**Tdap**

POLIO IPV/oral				

M/M/R Measles/Mump/ Rubella			

Chicken Pox (Vaccine/Disease month/year)

HEPATITIS B VACCINES

HIB VACCINES (Haemophilus Influenza)

HPV (Human Papillomavirus)

Pneumococcal (Prevnar)

Hepatitis A Vaccines

Rotavirus

Other Vaccines Received, specify

Flu Vaccines

TB

Positive □
Negative □

Meningococcal Vaccine

Dose 1	Booster Dose

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PHYSICIAN: to complete this section.

Student's name_____ Date of Birth_____

Birth History: Full Term □ Premature □ Complications? _____

Allergies: _____What Reaction? _____

Asthma? _____ If yes, name of medication(s) _____

Current Medications? _____

Special Diet? _____ If yes, what type? _____

Hospitalizations? _____

Surgeries?_____

Neurological Problems/Seizures? _____

Significant Conditions? _____

Cause of Deafness? _____

Childhood Diseases: Chicken Pox□ Meningitis□ Other? _____

(Explain)

Special Testing (optional): HCT_____ Lead Level_____ Urine_____ Sickle Cell_____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ B/P: _____Pulse: _____

Eyes: _____ Heart: _____ Neurological: _____

Ears: _____ Abdomen:_____ Spine: _____

Nose: _____ Genitalia_____ Extremities: _____

Throat: _____ Urinary: _____ Skin: _____

Chest: _____ Hernia: _____ Emotional Status: _____

Names of specialist (s) consulted: _____

Able to participate in

Athletic Programs? _____ If no, list restrictions: _____

Intramural Programs? _____ If no, list restrictions: _____

Physical Education? _____ If no, list restrictions: _____

Please list any activity to be avoided: _____

Date of Examination: _____ _____

Health Care Provider's Address

_____ _____

Health Care Provider's Signature Health Care Provider Fax

_____ _____

Health Care Provider's Printed Name **Health Care Provider Phone**