South Bend Community School Corporation
Health Questionnaire

Physician Physical Examination

Name: _____ DOB: _____

Date of Disease/Condition Code: No defect -0 Defect – note

Height: _____
Weight: _____
Blood Pressure: _____
Eyes: _____
Ear/Nose/Throat: _____
Heart/Chest: _____
Abdomen: _____
Hernia: _____
Extremities: _____
Neurological: _____
Skin: _____
Handicaps: _____
Other Findings: _____
Urine Analysis: _____
TB Test: _____
X-rays(s):_____
Strep: _____

Allergies: _____
Asthma: _____
Chicken Pox: _____
Diabetes: _____
Rubella: _____
Ear Infections: _____
Epilepsy: _____
Infectious Hepatitis: _____
Mononucleosis: _____
Sickle Cell: _____
Measles: _____
Pneumonia: _____
Dysmenorrhea: _____
Scarlet Fever: _____
Mumps: _____
Seizures: _____

Other: _____

Operations: _____ Chronic medical Conditions: _____
Severe Injuries: _____Severe/frequent illness: _____
Special Treatments: _____
List medications presently prescribed and why: _____

Are there any health issues/concerns which should be considered in planning this child's educational program: _____

Is this student physically fit to participate in the school physical education program?
Yes: ____ No: _____ If not, why? _____

Comments: _____

Physician/Practitioner's Name (please print) _____

Physician/Practitioner's Signature_____Date:_____

IMMUNIZATION RECORD

This can either be filled out by the physician or the physician can attach the official printed record from the physician's office to the physical examination form. **Please indicate month, day and year of vaccine.**

Vaccine	Date each dose was given									
	1st	2nd	3rd	4TH	5TH	6TH	7TH	8TH	9TH	10TH
Diphtheria Tetanus & Pertussis (DTaP)										
Polio (IPV)										
Measles, Mumps & Rubella (MMR)										
Hepatitis A										
Hepatitis B										
Meningococcal (MCV4)										
Tetanus, Diphtheria & Pertussis (Tdap)										
Varicella										
Haemophilus Influenza type b (HIB)										
Human Papillomavirus (HPV)										
Influenza (H1N1)										
Pneumococcal										
Rotavirus										

I, _____ (Parent) opt out of immunizing my child due to:

Religious: _____ Medical: _____
Date Date

PLEASE HAVE YOUR CHILD'S DOCTOR FILL OUT THIS FORM AND RETURN TO THE SCHOOL NURSE