

**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**

**DTaP or DT  
 TT or Tdap**

					<b>Tdap</b>
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**POLIO  
 IPV/oral**

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**Chicken Pox (Vaccine/Disease month/year)**

**M/M/R  
 Measles/Mump/  
 Rubella**

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**HEPATITIS B VACCINES**

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**HIB VACCINES (Haemophilus Influenza)**

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**HPV (Human Papillomavirus)**

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**Pneumococcal (Prevnar)**

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**Hepatitis A Vaccines**

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**Rotavirus**

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**Other Vaccines Received, specify**

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**Flu Vaccines**

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**TB**

Positive    
 Negative

**Meningococcal Vaccine**

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**PHYSICIAN: to complete this section.**

Student's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Birth History: Full Term  Premature  Complications? \_\_\_\_\_

Allergies: \_\_\_\_\_ What Reaction? \_\_\_\_\_

Current Medications? \_\_\_\_\_

Special Diet? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Hospitalizations? \_\_\_\_\_

Surgeries? \_\_\_\_\_

Neurological Problems/Seizures? \_\_\_\_\_

Significant Conditions? \_\_\_\_\_

Cause of Deafness? \_\_\_\_\_

Childhood Diseases: Chicken Pox  Date \_\_\_\_ Mumps  German Measles (Rubella)  Measles   
Rheumatic Fever  Meningitis  Roseola  Other: \_\_\_\_\_  
(Explain)

Special Testing: Lead Level: \_\_\_\_\_ Sickle Cell: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ HCT \_\_\_\_\_ Urine \_\_\_\_\_

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