

INDIANA SCHOOL FOR THE DEAF

General Medical Examination

(This form is required at school entry and at triennial. Failure to provide information will result in exclusion from school.)

Student's Full Name: _____ Birth date: ____/____/____

Sex: Male Female Race: _____ Grade: _____

Parent/Guardian's Name: _____

Address: _____ City/State/Zip Code: _____

Preferred contact number or email: (_____) _____

Insurance Company: _____ Insurance Policy #: _____

Notice to Parents/Physicians:

The Indiana Department of Health now requires that all students entering the kindergarten to have received at least two doses of measles vaccine, preferably M/M/R. Both doses may have been administered anytime during the student's life as long as there were 30 days between doses and after the first birthday.

IMMUNIZATION RECORD (Please indicate month and year)

DPT/DT Td or DTaP	1	2	3	4	5

ORAL POLIO (OPV) And/or IPV	1	2	3	4	5

M/M/R Measles/Mumps/ Rubella	1	2

TB Positive _____
 Negative _____

CHICKEN POX

 (VACCINE DATE)

HEPATITIS B VACCINES	1	2	3

HIB VACCINES Haemophilus Influenza	1	2	3	4

OTHER VACCINES RECEIVED	1	2	3

PARENTS: Please read and sign the following:

I understand that I am entrusting my child to the care of the school management while in attendance. **IN CASE OF EMERGENCY:** I understand every effort will be made to contact me as parent/guardian. In the event I cannot be reached, I hereby give permission to the physician selected by the Indiana School for the Deaf staff to secure appropriate treatment, including hospitalization, anesthesia, surgery or any needed medications for my child.

PARENTS: Please complete this section.

Parent/Guardian's Signature

Date

INDIANA SCHOOL FOR THE DEAF
MEDICAL HISTORY

Student's name _____ **Birth Date** _____

Birth History: Full Term Premature Complications? _____

Allergies: _____ What Reaction? _____

Current Medications? _____

Special Diet? _____ If yes, what type? _____

Hospitalizations/Surgeries? _____

Neurological Problems/Seizures? _____

Other health conditions? _____

Cause of Deafness? _____

Childhood Diseases: Chicken Pox 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: _____

Physician's Address

Physician's Signature

Physician's Fax Number

Physician's Printed Name

Physician's Phone Number

Parent/Guardian's Signature

Date

PHYSICIAN: to complete this section.