Community Action Program of Evansville and Vanderburgh County Inc.
Head Start/Early Head Start Site/Classroom _____

Physical Examination Record
(To be filled out only by a physician)

Name _____ Date _____

Address _____ Phone Number _____

Date of Birth _____ Sex _____ Family Physician _____

Physical Examination
(Circle: No defect—0: Defect—Note)

1. Height (in inches):_____ Weight:_____
   Head Circumference _____
2. Eyes:
   Vision (Snellen) Right _____
   Left _____
   Glasses Right _____
   Left _____
3. Ears: Right _____ Left _____
   Hearing: Right _____
   Left _____
4. Teeth: _____ Caries _____
5. Nose _____
6. Throat _____
7. Lymph Nodes _____
8. Thyroid _____
9. Heart _____
10. Blood Pressure _____
11. Lungs _____
12. Abdomen _____
13. Hernia _____
14. Orthopedic Impairments _____
15. Scoliosis Screening _____
16. Nutrition _____
17. Skin _____
18. Nervous Symptoms _____
19. Menstrual History _____
20. Ano-rectal _____
21. External Genitals _____
22. General Condition _____
23. History of severe illnesses, injuries or surgeries:_____
    _____
24. Ongoing Medical Concerns _____
    _____
    _____
    _____
    _____

Circle abbreviation of Immunization administered

Record of Required Immunizations

DPT.DTaP 1. _____ MMR 1. _____
DPT.DTaP 2. _____ 2, _____
DPT.DTaP 3. _____ 3. _____
DPT.DTaP 4. _____ Hepatitis B
DPT.DTaP 5. _____ 1. _____
DPT.DTaP 6. _____ 2. _____
3. _____

Td/Tdap 1. _____
2. _____ HIB 1. _____
3. _____ 2. _____
4. _____ 3. _____
4. _____

Polio Vaccine
OPV/IPV 1. _____ Prevnar 1. _____
OPV/IPV 2. _____ 2. _____
OPV/IPV 3. _____ 3. _____
OPV/IPV 4. _____ 4. _____
OPV/IPV 5. _____
OPV/IPV 6. _____ Varicella 1. _____
2. _____

Meningococcal 1. _____
MCV4/MPSV4 HPV 1. _____
2. _____
Other 1. _____ 3. _____
2. _____

Tests

Tuberculin Type _____ Date _____
Hemoglobin/Hematocrit _____
Lead Screen: Date _____ Results _____
Sickle cell Anemia: Yes _____ No _____ Results _____
Urinalysis: Date _____ Results _____
Allergies: _____
_____
_____

Physician's Recommendations

I recommend medical or dental attention to the following conditions:_____
_____

Student physically fit to participate in physical education? Yes _____ No _____

_____ _____ _____
Date Print Physician's Name Signature of Physician

5/15/14 CM