LAKEVIEW
CHRISTIAN SCHOOL

Physical Examination & Immunization History

TO BE COMPLETED BY PARENTS

Student last name		First name		Gender	☐ Male ☐ Female	DOB	
Address				Apartment/Unit #			
City		State		ZIP		Home phone	
School		Grade		Parent/guardian name			

IMMUNIZATIONS ARE REQUIRED AT TIME OF ENROLLMENT*: Indiana State Law requires completed immunizations for all schoolchildren. Please have your family physician record your child's immunization history below or return a copy of the most current immunization record to your child's school. Note that the law provides for exclusion from school for failure to comply with the immunization requirement, unless a parent submits a written statement of objection.*

TO BE COMPLETED BY PHYSICIAN

Physical examination

Date of exam								
HT		WT		BP		Lead testing - only if physician deems applicable		
Urine (If applicable):	Alb		Sugar		Test date		☐ capillary ☐ venous	Result

	Norm.	Abnorm.	Remarks
Abdomen	☐	☐	
Eyes	☐	☐	**Vision: RT LT**
ENT	☐	☐	
Extremities	☐	☐	
Heart	☐	☐	
Hernia	☐	☐	
Lungs	☐	☐	
Lymph nodes	☐	☐	
Nasopharynx	☐	☐	
Neuro	☐	☐	
Skeleton	☐	☐	
Skin	☐	☐	
Teeth & mouth	☐	☐	

Other conditions/disabilities		
Should child be restricted from physical activity? (If yes, please explain below)	☐ Yes ☐ No	

_____

_____

Medical history

Communicable disease	Month/year	Communicable disease	Month/year
Measles		Mumps	
Rubella (German measles)		Scarlet fever	
Chickenpox		Whooping cough	
Other		Other	

Please list any additional medical concerns or conditions that may handicap student below.

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_____

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Does this child have any health condition that would be hazardous either to the child or to other children in a group setting because of participation in normal activities (including sports)? ☐ **yes** ☐ **no**

If yes, please explain what modification of normal activities is necessary to protect the child and the child's classmates.

_____

_____

_____

Date(s) of immunization/test (please indicate month/day/year)

DTaP/DTP/DT/Td	1	2	3	4	5
Gardasil (HPV)	1	2	3		
Hepatitis A	1	2			
Hepatitis B	1	2	3		
Hib	1	2	3	4	
IPV	1	2	3	4	5
Menactra	1				
OPV	1	2	3	4	5
PCV7	1	2	3	4	
Teen Tdap	1				
Varicella	1	2	☐ Has had chickenpox	Date	
MCV4	1	2			

MMR#1		MMR#2		**OR**	Measles		Mumps		Rubella	
Most recent TB		Type		Result						
Other										

Physician signature		**Date**	