Dear Parents,

The health of your child has much to do with the child's happiness and well-being, as well as, with progress in school. This fact is so well recognized that your school requests that each child have at least three physical examinations during their school career, in order to be sure that their physical condition is good, and that no abnormalities have a chance to develop. Two of these examinations take place at the same grade level as required athletic physicals. One examination will satisfy both requirements.

Accordingly, a physical examination and a dental examination are requested of each pupil on entering school in Kindergarten, the fifth grade, and the tenth grade. Health authorities agree that the best type of physical examination is made in the office of the private physician. Your family physician is best qualified to judge the physical condition of your child, and explain to you his findings.

Please confer with your physician to see if your child's immunization status is complete and if not, to set up a schedule to do so. Immunizations are also available for a small fee ($1-$2) at the La Porte County Health Department.

Please ask your doctor and your dentist, to complete the enclosed physical and dental examination records. Forms are to be returned to the school as soon as they are completed.

If your child has had a physical examination within six months before entering the stated grade, your doctor may copy and send us those findings. This report becomes a part of your child's cumulative record.

We suggest that you schedule your child for his school physical as soon as possible so that a last minute rush can be avoided.

Thank you for your cooperation.

Sincerely,

Department of School Health Services

HLTH 5
NAME ______________________________ SEX __________ DATE OF BIRTH ________________

PARENTS ________________________________ ADDRESS ________________________________

SCHOOL ___________________________ GRADE ________ PHONE(for emer.)________________

TO BE ANSWERED BY PARENT: Are there any significant factors in your child's health history that could affect his/her mental or physical learning disability? Are there any allergies or other problems present of which the school health nurse should be aware? Is your child taking any medicine regularly? Please detail.

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

IMMUNIZATION RECORDS

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<td>IPV/OPV</td>
<td>MMR</td>
<td>TBC=Mantoux</td>
<td>Results</td>
<td>Other:</td>
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<td>Hep.B</td>
<td>Varivax</td>
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<td>M:</td>
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PHYSICAL EXAMINATION

Height ____________________ Weight____________________ Urinalysis ______________________

Please record any abnormal physical or developmental findings

____________________________________________________________________________________

____________________________________________________________________________________

Should physical activities be restricted?

Comments and recommendations

____________________________________________________________________________________

____________________________________________________________________________________

STATEMENT OF PHYSICIAN

This child has been adequately immunized ____________________________.

This child requires further immunizations which will be completed by me within 30 days

______________________________________________________________ within 60 days

This child requires further immunizations which should be completed by health department

Signed ________________________________________  Date ________________________________

Note: If student plans to participate in any school sports during the school year please fill in the form on the reverse side.

HLTH 6
PART II - STUDENT MEDICAL HISTORY (To be completed by parent or doctor)

Name of Student ____________________________________________

Parent's Name ____________________________________________ Phone ________________________

(Circle One)

Yes - No  1. Has had injuries requiring medical attention.
Yes - No  2. Has had illness lasting more than a week.
Yes - No  3. Is under physician's care now.
Yes - No  4. Takes medication now.
Yes - No  5. Wears glasses. Contact lenses Yes - No
Yes - No  6. Has had surgical operation.
Yes - No  7. Has been in the hospital (except for tonsillectomy)
Yes - No  8. Do you know of any reason why the individual should not participate in all sports?
Please explain any "Yes" answers to above questions.
_____________________________________________________________________________

Yes - No  9. Has had complete poliomyelitis immunization.
Yes - No  10. Has had a dental check-up within the past 6 months.

11. Most recent tetanus toxoid immunization date. ______________________

PART III - PARENT AND STUDENT CONSENT (To be completed and signed by parent or guardian
and student) In accordance with rules of the IHSAA, I hereby give my consent for the above named
student to participate in the following interschool sports NOT MARKED OUT:

**Boys Sports** - Baseball, Basketball, Cross Country, Football, Golf, Swimming, Tennis, Track,
Wrestling. **Girls Sports** - Basketball, Cross Country, Golf, Gymnastics, Softball, Swimming,
Tennis, Track, Volleyball

I understand that participation may necessitate travel and early dismissal from classes. Please
check appropriate space: He/She has school student accident insurance ( ); has football insurance
through the school ( ); has adequate family insurance coverage ( ).

Date __________________; Parent-Guardian Signature ________________________________

Student Signature _______________________________________

PART IV - PHYSICIAN'S CERTIFICATE (To be completed annually by physician holding unlimited
license to practice medicine.) (Cooperatively Prepared by the National Federation of State High School
Associations & the Committee on Medical Aspects of Sports of the AMA-IMA)

Name of Student ______________________________ School ____________________________

Significant past illness or injury _____________________________________________________

Grade ______; Age ______; Height ________; Weight ________; Blood Pressure ________


N.E.
Vision Musculoskeletal
Hearing Skin
Respiratory Neurological
Cardiovascular Lab
Tests/Urinalysis
Liver, Spleen, Kidney Other
Hernia, Genitalia

I certify that I have on this date examined this student as indicated and find him/her physically able to
compete in supervised athletics NOT MARKED OUT BELOW.

**Boys Sports** - Baseball, Basketball, Cross Country, Football, Golf, Swimming, Tennis, Track,
*Wrestling. **Girls Sports** - Basketball, Cross Country, Golf, Gymnastics, Softball, Swimming, Tennis,
Track, Volleyball.

*Weight loss permitted to make lower weight class in Wrestling? Yes _____; No _____;
If yes, may lose _________ pounds.

Date of Examination __________________; Signed ________________________________ M.D.