Special **E**ducation **L**earning **F**acility
750 Ransom Road, Valparaiso IN 46385
Phone: {219} 548-3162 Fax: {219} 462-0867

TO BE COMPLETED BY A REGISTERED PHYSICAN

Student Name;_____ Date:_____

D.O.B.:_____ WEIGHT:_____ HEIGHT: _____ B/P:_____

Eyes	Extremities
Glasses	Posture {spine}
Nose	Skin
Throat	Allergy
Teeth	General Appraisal
Heart	
Lungs	
Abdomen	
Hernia	

Special Medications:_____

_____

Recommendation or restrictions while at school:_____

_____

Immunizations: Indicate month, day and year

DPT/DTAD/TD/Dtap	1.	2.	3.	4.	5.	6.
OPV/IPV	1	2.	3.	4.	5.	
MEASLES	1.	2.				
MUMPS	1	2.				
RUBELLA	1.	2.				
HEPATITIS A	1	2.				
HEPATITIS B	1.	2.	3.			
HIB	1	2.	3.	4.		
VARICELLA	1.	2.				
TB TEST	DATE: TYPE: RESULTS:					

Physician's signature:_____ Date:_____

Physician's address:_____

Physician's phone:_____ Fax:_____

2/22/10