List dates (month-day-year)

Type of vaccine	1st	2nd	3rd	4th	5th
DTaP/DTP/Tdap (Diphtheria, Tetanus, Pertussis)					
DT					
Td					
OPV/IPV (polio)					
MMR (Measles, Mumps, Rubella)					
Measles					
Mumps					
Rubella					
HIB					
TB Test (type & result)					
Hepatitis B					
Varicella (chicken pox vaccine)					
Other					

Follow-up Notes:

Physical Examination Form

Student's Name: ______________________________

Birth Date: ________________ **Sex:** ______________

Parent/Legal Guardian: ________________________

Physician's Name: ____________________________

Physician's Phone #: __________________________

To Parent/Legal Guardian:

In accordance with the recommendations of the St. Louis Archdiocese Health Advisory Committee, all children are expected to have a complete physical examination upon entrance to kindergarten, 3rd grade, 6th grade 9th grade, and all newly enrolled students who have not had a physical examination within the past 12 months. The physical examination must be completed and signed by a medical doctor or physician assistant/nurse practitioner working under a collaborative practice agreement with a medical doctor.

This form is provided for the convenience of your child's physician. At the time of the examination, please have your physician complete and sign this form. It is expected that each student have this form on file at school by the first day of school.

School Name: ______________________________

School Address: ____________________________

School Phone: ______________________________

Medical History: (To be completed by parent)

Eyes: Glasses___ (reading____ distance____)
Contacts_____ other

____

Ears: frequent infections___________________________
tubes_____
hearing difficulty
(explain)_____________________________________
hearing aid - right_____ left______ wear at school_____

Allergies: (drugs, food, insects, pollens)
Please list:

____

Has the allergy ever required emergency action? (explain)

____

Asthma: Yes_____ No_____
Triggered by:

____

Treatments/Medications:

____

Diagnosed by physician (date): ___________________

Seizures: Yes_____ No_____
Date of last seizure: __________
Describe seizure:

____

Medication:

____

Other Medications/Inhaler:

____

____

Reasons for
taking:_______________________________________

Other Health Concerns: diabetes____ heart ____
problem____ bleeding_____ eating_____ sleeping____
bowel____ bladder____ bed wetting____ dental_____
skin____ menstrual history_____ phobias (fears)_____
blood pressure____ orthopedic____ neurologic____
head aches____ blood disorder____ lungs____
sickle cell anemia_____ TB exposure_____
EXPLAIN:_____________________________________

____

____

Other illness, injury, or health problem that might affect performance at school:

____

____

Physical Examination: (To be completed by physician)

Growth Measurements:

Height: __________ Weight: ___________

Dietary restrictions:

____

Physiologic Measurements:

Temp: ________

Pulse: __________

Respiration: __________

Blood Pressure: __________

Urinalysis: _____________

Physical Exam:

General Appearance:

____

Skin:

____

Head:

____

Neck:

____

Eyes:

____

Vision Test: Both ______ Right ______ Left ______

Ears:

____

Hearing Test: pass fail

Nose/Mouth/Throat:

____

Chest:

____

Abdomen:

____

Genitalia:

____

Back and Extremities:

____

Neurologic Exam:

____

Chronic conditions and treatment:

____

____

____

Should physical activity be restricted?

yes____ no_____

If yes, specify degree____

Other restrictions

____

Preferential Seating_____________________________

Signature:_______________________________________

Date:___________ Date of Examination:__________