Physical Examination Form

Student's Name: _____

Address: _____

Phone Number: _____

Birth Date: _____ Sex: _____

Parent/Legal Guardian: _____

Physician's Name: _____

Physician's Phone #: _____

Dentist's Name: _____

Dentist's Phone Number: _____

To Parent/Legal Guardian:

In accordance with the recommendations to the St. Louis Archdiocese Health Advisory Committee, all children are expected to have a complete physical examination upon entrance to school. Kindergarten, 3rd grade, 6th grade, and all newly enrolled students.

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.

Immunization Record:					
Type of vaccine	1st	2nd	3rd	4th	5th
DTaP/DTP (Diptheria, 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)					
HepatitisA* *not requited as of 2001 Other:					
Menactra					
HPV					

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: _____

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 ___ headaches ___ blood disorder ___ lungs ___
sickle cell anemia ___ TB exposure ___
EXPLAIN: _____
_____

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