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| **Physician Physical Examination Form**  **(Please attach a copy of the current Immunization Records)** |

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| **Student’s Name:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Physician’s Name:** |  |
| **Physician’s Phone Number:** |  |
| **Date of Examination:** |  |

***Please have your physician complete the following:***

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| --- | --- | --- | --- | --- | --- |
| Height | Weight | BP | Pulse | BMI | Temperature |

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| --- | --- | --- | --- | --- |
| Nutrition | Nose | Abdomen | Skin | Mouth |
| Back | Lungs | Genitalia | Head | Throat |
| Extremities | Heart | Neck | Dietary | Neurologic Exam |
| Ears/Hearing Test:  Right:  Left: | Eyes/Vision Check:  Right:  Left: | Should physical activity be restricted?  **Yes** or **No** | Dental | Known Allergies: |

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| Physician Comments and/or Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chronic Conditions & Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please place office stamp below:  **Please attach a copy of the most current Immunization Records** |

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| Student Medical History  (To be completed by the Parent/Legal Guardian) |

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 Preschool, 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, stamp and sign the opposite side of the form. The Parent/Legal Guardian is to complete the “Student Medical History” portion.It is expected that each student has this form on file at school by the first day of school.

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| **Eyes**: Glasses\_\_\_\_\_ Contacts \_\_\_\_\_ (For reading \_\_\_\_\_ distance\_\_\_\_\_)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ears**: Frequent Infections \_\_\_\_\_ Tubes \_\_\_\_\_ Hearing Difficulty \_\_\_\_\_  Hearing Aid\_\_\_\_\_ (Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_)  Wears at school \_\_\_\_\_ Yes \_\_\_\_\_ No |
| **Allergies**: (Drugs, Food, Insects, Pollens, etc…)  Please list any known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Action Plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Asthma**: Yes\_\_\_\_\_ No \_\_\_\_\_ Triggered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatments/Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosed by physician (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Seizures**: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe the seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other Medications/Inhaler**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Please indicate health concerns below:***   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Diabetes | Heart Problem | Bleeding | Eating | Sleeping | | Bowel | Bladder | Bed Wetting | Dental | Skin | | Phobias | Blood Pressure | Orthopedic | Neurological | Headaches | | Blood Disorder | Lungs | Sickle Cell Anemia | TB Exposure | Menstrual History |   Other Health Concerns: |