

Grade Entering _____

School Year: 2020-- 2021

List Dates (month – day – year)

Physical Examination Form

Type of vaccine	1 st	2 nd	3 rd	4 th	5 th
DTaP/DTP (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:

THIS FORM MUST BE RETURNED TO THE SCHOOL OFFICE BY:

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.

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: St. Gerard Majella

School Address: 2005 Dougherty Ferry Road, Kirkwood MO 63122

School Phone: (314) 822-8844

Physical Examination Form – St. Gerard Majella

Medical History (to be completed by parent)

Eyes: Glasses ____ (reading ____ distance ____) Contacts ____
Other _____
Ears: Frequent infections _____
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 Medication/Inhaler: _____
Reasons for taking: _____
Other Health Concerns:

<input type="checkbox"/> yes	<input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	heart problems
<input type="checkbox"/> yes	<input type="checkbox"/> no	bleeding	<input type="checkbox"/> yes	<input type="checkbox"/> no	eating
<input type="checkbox"/> yes	<input type="checkbox"/> no	sleeping	<input type="checkbox"/> yes	<input type="checkbox"/> no	bowel
<input type="checkbox"/> yes	<input type="checkbox"/> no	bladder	<input type="checkbox"/> yes	<input type="checkbox"/> no	bed wetting
<input type="checkbox"/> yes	<input type="checkbox"/> no	dental	<input type="checkbox"/> yes	<input type="checkbox"/> no	skin
<input type="checkbox"/> yes	<input type="checkbox"/> no	menstrual history	<input type="checkbox"/> yes	<input type="checkbox"/> no	phobias(fears)
<input type="checkbox"/> yes	<input type="checkbox"/> no	blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	orthopedic
<input type="checkbox"/> yes	<input type="checkbox"/> no	neurological	<input type="checkbox"/> yes	<input type="checkbox"/> no	head aches
<input type="checkbox"/> yes	<input type="checkbox"/> no	blood disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	lungs
<input type="checkbox"/> yes	<input type="checkbox"/> no	sickle cell anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	TB exposure
<input type="checkbox"/> yes	<input type="checkbox"/> no	bee allergy			

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:
Temperature: _____ 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 & Extremities: _____
Neurological Exam: _____
Chronic conditions and treatment: _____

Should physical activity be restricted? Yes ____ No ____
If yes, specify degree: _____
Other restrictions: _____
Preferential Seating: _____
Signature: _____ Date of Exam: _____
Date: _____