

Grade Entering \_\_\_\_\_

School Year: 2021-- 2022

List Dates (month – day – year)

Physical Examination Form

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

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, 3<sup>rd</sup> grade, 6<sup>th</sup> grade, 9<sup>th</sup> 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:** \_\_\_\_\_