Medical History Form

Student's Name_____ Gr._____

Doctor's name _____ Physical exam within the last two years? Yes__ No__
Dentist's name _____ Physical exam within the last two years? Yes __ No __

Vision (Eyes): Glasses____ (reading___ distance_____) Contacts_____
Comments: _____

Hearing: frequent infections_____
Hearing difficulty (explain) _____
Hearing aid – right_____ left_____ wears at school_____

Allergies: (drugs, food, intolerances, insects, pollens, animals)
Please list_____
Action plan from doctor _____ Copy sent to school _____**(please have copy sent to school with ALL allergies listed)**
Describe how allergy reaction occurs: ___ingestion ___touch ___smell ____airborne ____

Asthma: Yes ___ No ___ Triggered by: _____
Treatments: ____ Will medication need to be kept at school for emergency? _____
Exercise limitations: _____

Seizures: Yes___ No ___ Last date of seizure: _____
Describe seizure: _____
Medication being taken: _____

Medications taking on a daily bases and reasons for taking them: _____

_____

Other Health Concerns:

diabetes __ heart problems __ blood disorder __ eating ___ sleeping __ bowel __ bladder __ bed wetting __

lungs __ blood pressure __orthopedic __ neurologic __ headaches

Explain: _____

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

Signature of Parent or Legal Guardian_____ Date_____

PHYSICIAN AUTHORIZATION FOR
OVER THE COUNTER MEDICATIONS

Name of Student_____Date of Birth_____

Address_____Grade_____
Street City/State/ZIP

Name of Licensed Prescriber_____Title_____

Doctor's Telephone #_____

I HAVE DETERMINED THAT IT IS NECESSARY FOR THIS MEDICATION TO BE ADMINISTERED DURNING SCHOOL HOURS AS PER PARENT/GUARDIAN INSTRUCTIONS.

Please circle the medications that may be given at school. Medications will be given as per product instructions:

Acetaminophen: child/adult
Antibiotic ointment
Cough drops
Ibuprofen
Motrin: child/adult
Tums
Other:_____

Cough syrup
Sinus tablets
Benadryl cream
Burn gel
Saline solution
Calamine lotion

Advil: child/adult
Aleve: child/adult
Benadryl liquid/tablets
Chap Stick

Other specific directions or information regarding this medication administration:

_____

Specific side effects, contraindications or possible adverse reaction to be observed:

_____

_____
Signature of licensed prescriber

_____
Signature of parent/guardian

_____
Title

_____
Date

_____
Date

Physical Examination Form

In accordance with the recommendations of the Saint Louis Archdiocese Health Advisory Committee, **all children are expected to have a complete physical examination upon entrance to preschool, prekindergarten, kindergarten, 3rd grade, 6th grade, 9th grade, and all newly enrolled students who have not had a physical examination within the past twelve (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: **St. Francis Borgia Grade School** Grade: _____

Student's Name _____ DOB _____ M or F _____

Date of Examination _____

Height _____ Weight _____ BP _____ Pulse _____ BMI _____

General Appearance
Nutrition _____ Nose ____ Abdomen ____ Skin ____ Mouth ____ Back ____ Lungs ____
Genitalia _____ Head ____ Throat ____ Extremities _____ Heart _____ Neck _____ Eyes _____
Neurologic Exam _____
Please list any allergies _____

Physician Comments & Recommendations (give details of management of significant illnesses)

_____

_____

Can student carry a full program of school work? Yes No (circle one)
Should physical activity be restricted? Yes No
Explain _____

Hearing Test: Type of test _____ R L Both
Vision Test: Type of test _____ R L Both

Physicians Signature _____ Date _____
Print Physicians Name _____

Office Stamp

Please Attach a Copy of the Current Immunization Record.
Please Attach a Copy of any action plans regarding allergies and other medical conditions.

MEDICAL STATEMENT FOR STUDENT REQUIRING MEAL MODIFICATION

Name of Student	Date of Birth
Name of Parent/Guardian	Parent/Guardian Contact Phone
Local Education Agency	School Attending

For Completion By Medical Authority: *Physician (M.D. or D.O.), Physician's Assistant, Assistant Physician or Nurse Practitioner*

Identify the child's physical or mental impairment and how it restricts the child's diet, including allergies, requiring the student to have a modified diet.

Explanation of what must be done to accommodate the child.

Omitted Foods Listed Below	Substitute Foods Listed Below	
Medical Authority Printed Name	Title	
Medical Authority Signature	Telephone Number	Date

Parent/Guardian Permission: *To be completed by a parent/guardian*

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Signature of Parent/Guardian	Date