

Physical Examination & Medical History Form

Dear 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 **Pre-School, Kindergarten, 3rd & 6th Grade, and all newly enrolled students**, who have not had a physical examination within the past 12 months. **Please fill out the Medical History on this side. The physical examination, on the reverse side, must be complete and signed by a medical doctor or physician assistant/nurse practitioner** working under a collaborative practice agreement with a medical doctor.

It is expected that each student have this form on file by the first day of school.



Medical History: (To be completed by Parent/Guardian)

Student Name: _____ **Grade in Fall:** _____

Parent/Legal Guardian: _____ **Physician Name:** _____

Eyes: Glasses _____ (reading _____ distance _____) Contacts _____ Other: _____

Ears: Frequent infections: _____ Tubes: _____ Hearing difficulties (explain) _____

Allergies: (food, drugs, insects, pollen, etc.) _____

Treatment/Medications: _____

Severe Food Allergies require a Food Allergy Action Plan (obtain from Physician or Health Rm)

Asthma: _____ Triggered by: _____

Treatment/Medications: _____

Diagnosed by Physician (date): _____

Seizures: _____ Date of last seizure: _____ Describe: _____

Medication: _____

Diabetes: _____ **Requires a Diabetes Action Plan** (obtain from Physician or Health Rm)

Other Medications & reason for taking: _____

Other Health Issues/Concerns: Heart _____ Eczema _____ Lungs _____ Headaches _____
Bleeding _____ Bladder _____ Bowel _____ Orthopedic _____
Eating _____ Dental _____ Sleeping _____ Phobias (fears) _____

Explain: _____

Any other illness, injury or health problem that might affect performance at school: _____

_____ (over)

Physical Examination: (To be completed by Physician)

Student's Name: _____ **Date of Birth:** _____ **M or F**

Ht. _____ Wt. _____ Temp _____ BP _____ Pulse _____ Resp _____ BMI _____

General Appearance: _____ Nose/Mouth/Throat: _____

Skin: _____ Chest: _____

Head: _____ Abdomen: _____

Neck: _____ Genitalia: _____

Eyes: _____ Back & Extremities: _____

Vision Test Type: _____ Neurologic Exam: _____

R _____ L _____ Both _____

Hearing Test Type:

R _____ L _____ Both _____

Physician Comments & Recommendations: _____

Can student carry a full program of school work? Yes No (circle one)

Should physical activity be restricted? Yes No

Explain: _____

Physician Signature: _____ **Date:** _____

****PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD****

For over-the-counter Advil (Ibuprofen) or Tylenol (Acetaminophen), as needed, please be sure the following is filled out completely. Student may receive the following medication:

Tylenol (dose) _____ every 4 hrs. or **Advil (dose)** _____ every 6 hrs. as needed for headache/pain.

Allergy to medications: _____

Parent signature: _____ Date: _____

Physician's Signature: _____ **Date:** _____