

PHYSICAL EXAM FORM

Student Name: _____

Birthdate: _____ **Sex:** _____

Parent/Legal Guardian: _____

Physician's Name: _____

Physician's Phone: _____

Physician's Fax: _____

To Parent/Legal Guardian:

In accordance with the recommendations of the St. Louis Archdiocese Health Advisory Committee, all children are to have a complete physical exam upon entrance to the school-kindergarten, 3rd grade, 6th grade, and all new entrants.

This form is provided for the convenience of your child's physician. At the time of the exam, please have the doctor complete and sign this form. All students must present an up to date immunization record obtained from the physician as well.

It is expected that each student have these forms on file at the school by the first day of school.

SACRED HEART CATHOLIC SCHOOL

501 ST. LOUIS STREET

FLORISSANT, MO 63031

PHONE: (314)-831-3372

FAX: (314)-831-2844

MEDICAL HISTORY: TO BE COMPLETED BY PARENT

EYES: Glasses _____ (reading _____ distance _____)

Contacts _____ Other _____

EARS: Frequent infections _____ Tubes _____

Hearing Aid right _____ left _____ @school _____

MEDICATION: _____

Reason: _____

ALLERGIES: Drugs, Food, Insects, Pollens, etc.

Please list: _____

Has the allergy ever required emergency action?

Explain: _____

ASTHMA: Yes _____ No _____ Triggered by: _____

Treatments: _____

Diagnosed by Physician (Date) _____

SEIZURES: Yes _____ No _____ Date of last seizure _____

Medication: _____

OTHER HEALTH CONCERNS: Diabetes _____ Bleeding _____

Heart Problem _____ Eating _____ Sleeping _____ Dental _____

Bowel/Bladder _____ Bed-wetting _____ Skin _____ Lung _____

Phobias (fears) _____ Menstrual history _____ Headaches _____

Blood pressure _____ Orthopedic/neurologic _____

Sickle cell anemia _____ Blood disorder _____ TB exposure _____

Explain: _____

Other illness, injury, or health problems that might affect the child's performance at school: _____

PHYSICAL EXAMINATION: COMPLETED BY PHYSICIAN

GROWTH MEASUREMENTS:

Height: _____ Weight: _____

Dietary Restrictions: _____

PHYSIOLOGIC MEASUREMENTS:

Temp: _____ Pulse: _____ Resp: _____

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: _____

Back/Extremities: _____

Genitalia: _____

Neurologic Exam: _____

CHRONIC CONDITIONS/TREATMENT:

_____ Should

physical activity be restricted: Yes No

If yes, specify degree: _____

Other restrictions/Preferred seating: _____

SIGNATURE: _____

DATE OF EXAMINATION: _____