Grade Entering _____

School Year: 2012 – 2013

List Dates (month – day – year)

Type of vaccine	1st	2nd	3rd	4th	5th
DTaP/DTP (Diphtheria, Tetanus, Purtussis)					
DT					
Td					
Tdap (by 8th Grade)					
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: August 8, 2012

Physical Examination Form

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: **Ascension Catholic School**

School Address: **238 Santa Maria Dr. Chesterfield, MO**

School Phone: **(636) 532-1151**

Physical Examination Form – Ascension Catholic School

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:

❑ yes	❑ no	Diabetes	❑ yes	❑ no	heart problems
❑ yes	❑ no	bleeding	❑ yes	❑ no	eating
❑ yes	❑ no	sleeping	❑ yes	❑ no	bowel
❑ yes	❑ no	bladder	❑ yes	❑ no	bed wetting
❑ yes	❑ no	dental	❑ yes	❑ no	skin
❑ yes	❑ no	menstrual history	❑ yes	❑ no	phobias(fears)
❑ yes	❑ no	blood pressure	❑ yes	❑ no	orthopedic
❑ yes	❑ no	neurological	❑ yes	❑ no	head aches
❑ yes	❑ no	blood disorder	❑ yes	❑ no	lungs
❑ yes	❑ no	sickle cell anemia	❑ yes	❑ no	TB exposure
❑ yes	❑ 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: _____ **Date of Exam:** _____