St. Clare of Assisi School
15668 Clayton Road, Ellisville, MO 63011

School Fax: (636) 394-0359
Health Room: (636) 227-8654 ext. 136

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:** ____________________

Revised: October 2017

(over)