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 **Pre-School, 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 _____ 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

History/Medical Diagnosis - Please check any that apply and return to school office

☐ ADHD ☐ ***Asthma** ☐ Autism ☐ ***Diabetes** ☐ Heart/Lung ☐ ***Seizure Disorder** date of last seizure _____

☐ ***Allergies (specify)**

Drug Allergies	Food Allergies	Insect/Bee Allergies	Other Allergies

*** Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc… will need an Action/Care Plan completed by the physician.**

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

Physician Signature _____ Date_____

Print Physician Name_____

PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD