

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:

- | | | | | | |
|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|----------------|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no | heart problems |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | bleeding | <input type="checkbox"/> yes | <input type="checkbox"/> no | eating |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | sleeping | <input type="checkbox"/> yes | <input type="checkbox"/> no | bowel |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | bladder | <input type="checkbox"/> yes | <input type="checkbox"/> no | bed wetting |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | dental | <input type="checkbox"/> yes | <input type="checkbox"/> no | skin |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | menstrual history | <input type="checkbox"/> yes | <input type="checkbox"/> no | phobias(fears) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no | orthopedic |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | neurological | <input type="checkbox"/> yes | <input type="checkbox"/> no | head aches |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | blood disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no | lungs |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | sickle cell anemia | <input type="checkbox"/> yes | <input type="checkbox"/> no | TB exposure |
| <input type="checkbox"/> yes | <input type="checkbox"/> 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:** _____

Grade Entering _____

School Year: 2009 – 2010

List Dates (month – day – year)

| Type of vaccine | 1 st | 2 nd | 3 rd | 4 th | 5 th |
|---|-----------------|-----------------|-----------------|-----------------|-----------------|
| DTaP/DTP (Diphtheria, Tetanus, Pertussis) | | | | | |
| DT | | | | | |
| Td | | | | | |
| OPV/IPV (polio) | | | | | |
| MMR (Measles, Mumps, Rubella) | | | | | |
| Measles | | | | | |
| Mumps | | | | | |
| Rubella | | | | | |
| HIB | | | | | |
| TB Test (type & result) | | | | | |
| Hepatitis B | | | | | |
| Varicella (chicken pox vaccine) | | | | | |
| Other: | | | | | |

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.***

Follow-Up Notes:

THIS FORM MUST BE RETURNED TO THE SCHOOL OFFICE BY: August 12, 2009

School Name: **Ascension Catholic School**

School Address: **238 Santa Maria Dr. Chesterfield, MO 63005**

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