St. Paul's Lutheran School
1300 N. Ballas Rd, Des Peres, MO 63131
314-822-2771
FAX 314-822-6574

IMMUNIZATION AND HEALTH INFORMATION

(For all students)

PHYSICIAN EXAM FORM

(For Student entering Kindergarten, 4th & 7th grade, and all sports participants)

To be Completed by Parent:

Student Name:

Address: City, State Zip

Date of Birth: Gender: *(circle one)* M F Grade:

Parent/Guardian:

Home Phone # Cell Phone #

To be Completed by Parent:
Student Health History:

Has child ever had any of the following? (Please circle.) If yes, please explain.

Asthma Y N

Epilepsy Y N

Diabetes Y N

Chicken Pox Y N

Other Serious Illness Y N

Surgeries Y N

Allergies Y N
(If yes, please list what child is allergic to.)

Medications *(current or past)* Y N

Student Orthopedic History:

(for sports participation only)

Head Injury Y N

Neck/Back Y N

Hip/Leg/Foot Y N

Other Serious Injury Y N

Immunizations (mm/dd/yyyy)

HIB _____ _____ _____ _____
DTP _____ _____ _____ _____
Tdap _____
Polio _____ _____ _____ _____
MMR _____ _____
MCV _____
Hep B _____ _____ _____
Chicken Pox _____ _____ _____ _____
Other _____

To be Completed by Physician:

(For students entering Kindergarten, 4th Grade 7th Grade, new to the school, or are intending to participate in sports.)

Is child under care at this time? Y N

If yes, please explain:

Physical Findings

Height _____
Weight _____
B/P _____
Pulse _____
Eyes _____
Snellen _____
Cover Test _____
ENT _____
Chest/Lungs _____
Heart _____
Abdomen _____
Hernia _____
Lymph Nodes _____
Genitalia _____
Neurology _____
Scoliosis _____

To be Completed by Physician:

Recommendation for School

Special Seating Recommended Y N

Medical Treatment at School Y N

Orthopedic Exam

(For sports participation)

ROM _____
Back _____
Neck Shoulder _____
Upper Extremities _____
Lower Extremities _____

Recommendation for Sports
(Check one.)

_____ Full Unlimited Participation
_____ No Participation
_____ Limited Participation
_____ Clearance withheld until _____

_____
Name of Examiner (please print)

_____
Signature of Examiner

Date _____

Address _____

_____

Phone _____

FAX _____

Parent's or Guardian's Permission for Interscholastic Sports Activities

I hereby give my consent for the student to represent his/her school in interscholastic activities, except those stated on this form by the physician. I also give my consent for him/her to accompany the team in its travels to practices, games or related activities sponsored by the school and will not hold the school responsible in case of accident or injury. I also give consent and authorize the school to obtain, through a physician of its choice such as medical care as is reasonably necessary for the welfare of the student, if she/he is injured in the course of school athletic activities. I also give consent for the school nurse or administrator to contact the child's physician concerning health issues.

Parent's Signature _____ Date _____