

**ST. ROSE PHILIPPINE DUCHESNE SCHOOL**  
***“The Shining Star: Enlightening Minds, Reflecting Faith”***

**Spring, 2009**

Dear Parents/Guardians,

Students who are entering Kindergarten, 4th, and 7th grades, and those who are new to the school, no matter what grade, are required to have a complete physical examination, up-to-date immunization (shot) records, and a medical history (completed by the parent) included in their school record.

These documents are required prior to the first day of school. Students will not be allowed in school unless all required documentation has been received and reviewed.

The required school immunizations for the 2009-2010 school year are noted in the graph below. Please be aware that if the child has had chickenpox, a statement signed by the parent/guardian or physician indicating the month and year of the disease is required.

If you have any questions concerning any of the information contained in this packet, please contact the school nurse or office at 314-921-3023.

# Physical Examination Form

Grade \_\_\_\_\_

## To Parent/Legal Guardian:

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. Each applicable student must have this form on file at school by the first day of school.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

IMMUNIZATION RECORD (List dates by month/date/year)					
DPT	_____	_____	_____	_____	_____
DTap	_____	_____	_____	Td	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____	VARIVAX	_____	_____
HEP B	_____	_____	_____		
HIB	_____	_____	_____	_____	
HEP A	_____	_____	_____		
Pneumo	_____	_____	_____	_____	

**STUDENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Medical History: (To be completed by parent)**

**Eyes:** Glasses \_\_\_\_\_ (reading \_\_\_ distance \_\_\_) Contacts \_\_\_\_\_ Other \_\_\_\_\_

**Ears:** Frequent infections \_\_\_ Tubes \_\_\_\_\_ Hearing difficulty (explain): \_\_\_\_\_

Hearing aid – right \_\_\_\_\_ left \_\_\_\_\_ Worn at school \_\_\_\_\_

**Allergies: (drugs, food, insects, pollens)** Please list: \_\_\_\_\_

**Has the allergy ever required emergency action?** Explain: \_\_\_\_\_

**Asthma:** Yes \_\_\_ No \_\_\_ Triggered by: \_\_\_\_\_

Treatments: \_\_\_\_\_

Diagnosed by physician: \_\_\_\_\_ Date: \_\_\_\_\_

**Seizures:** Yes \_\_\_ No \_\_\_ Date of last seizure: \_\_\_\_\_

Describe seizure: \_\_\_\_\_

Medication: \_\_\_\_\_

**Other Medications:** \_\_\_\_\_

Reasons for taking: \_\_\_\_\_

**Other Health Concerns:** Diabetes \_\_\_ Heart Problem \_\_\_ Bleeding \_\_\_ Eating \_\_\_

Sleeping \_\_\_ Bowel \_\_\_ Bladder \_\_\_ Lung \_\_\_ Bed wetting \_\_\_ Dental \_\_\_

Skin \_\_\_ Menstrual History \_\_\_ Phobias (fears) \_\_\_ Blood Pressure \_\_\_

Orthopedic \_\_\_ Neurologic \_\_\_ Head Aches \_\_\_ Blood disorder \_\_\_

Sickle Cell Anemia \_\_\_ TB exposure \_\_\_

Explain: \_\_\_\_\_

**Other Illness, Injury, or health problem that might affect performance at school:**

**STUDENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Physical Examination: (To be completed by physician)**

**Growth Measurements:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dietary restrictions: \_\_\_\_\_

---

**Physiologic Measurements:** Temp: \_\_\_\_\_ 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 and Extremities: \_\_\_\_\_

Neurological Exam: \_\_\_\_\_

**Chronic conditions and treatment:** \_\_\_\_\_

---

Should physical activity be restricted? Yes \_\_\_ No \_\_\_

If yes, specify degree: \_\_\_\_\_

Other restrictions: \_\_\_\_\_

Preferential Seating: \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date of Examination:** \_\_\_\_\_