Annual Student Health Information

Please print:

_____ _____ _____ ____ __M ___F

Last name First name Birthdate Grade

History/Medical Diagnosis

Please check any that apply:

__ADHD __Anxiety __*Asthma __*Diabetes __*Seizure Disorder (date of last seizure)_____

***Allergies (please specify)**

Drug allergies:_____

Food allergies:_____

Other allergies;_____

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

__Hearing loss/Aids __Glasses/contacts

__Other health information _____

__No known health problems

Medications

Please list all medications given at home and/or school:

Medication_____Reason_____Dose_____Time_____

Medication_____Reason_____Dose_____Time_____

Medication_____Reason_____Dose_____Time_____

***Any medication to be administered at school requires the completion of Authorization of Medication Administration in School form.**

Parent/Guardian Name (print):_____

Parent/Guardian SIgnature:_____Date_____

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 _____

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

Office Stamp