



HEALTH EXAMINATION FORM 2010-2011

St. Joseph Elementary School
555 St. Joseph Lane, Manchester, MO 63021

Phone: 636-391-1253
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Physicals are due on/before July 15th. Physicals are required for students entering Pre-School, Kindergarten, Third Grade, Sixth Grade, and Transfer Students.

| TO BE FILLED OUT BY PARENT/LEGAL GUARDIAN | TO BE FILLED OUT BY DOCTOR | | | | | | | | | |
|--|---|------------------|-------------|------------------|---------------|--|---------------|--------------------|--|---------------|
| Student : _____ DOB: _____ | Date of Exam: _____ | | | | | | | | | |
| Address: _____ | Physical Findings: | | | | | | | | | |
| | HT _____ WT _____ | | | | | | | | | |
| Grade: _____ Gender: M F | B/P _____ Pulse _____ | | | | | | | | | |
| Parent/Guardian: _____ | Vision: Snellen Test _____/_____ Cover Test: _____ | | | | | | | | | |
| Home Phone: _____ | Hearing: PASS FAIL | | | | | | | | | |
| Work Phone: _____ | ENT <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Cel Phone: _____ | Respiratory <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| HEALTH HISTORY | Cardiac <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Has your child had any of the following: | Abdomen <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Asthma NO YES | Hernia <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Epilepsy | Lymph Nodes <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Diabetes | Neurologic <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Other | Genitalia <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Surgery | Scoliosis <input type="radio"/> Normal <input type="radio"/> Abnormal | | | | | | | | | |
| Past or Current Injury: Head _____ Neck Back _____ Shoulder/Arm/Hand _____ Hip/Leg/Foot _____ Other _____ | Recommendations for Medical Treatment in School: (if needed) | | | | | | | | | |
| Medications: | Orthopedic Exam: (for sports participation) | | | | | | | | | |
| Allergies | ROM: | | | | | | | | | |
| | Back: | | | | | | | | | |
| | Neck/Shoulders: | | | | | | | | | |
| | Upper Extremities: | | | | | | | | | |
| | Lower Extremities: | | | | | | | | | |
| | Other: | | | | | | | | | |
| MEDICAL HISTORY | RECOMMENDATIONS FOR SPORTS/SCHOOL: | | | | | | | | | |
| Is the child currently under medical care at this time? NO YES Explain: | <ul style="list-style-type: none"> • Full unlimited participation YES • Limited participation Attach accompanying explanation • Clearance withheld until: _____ | | | | | | | | | |
| IMMUNIZATIONS | Student may receive the following medications for fever, headache or pain: | | | | | | | | | |
| PLEASE ATTACH A COPY OF STUDENT'S COMPLETE IMMUNIZATION RECORD TO THIS FORM. | <table> <tr> <td></td> <td><u>DOSE</u></td> <td><u>Frequency</u></td> </tr> <tr> <td>TYLENOL _____</td> <td></td> <td>Every 4 Hours</td> </tr> <tr> <td>MOTRIN/ADVIL _____</td> <td></td> <td>Every 6 Hours</td> </tr> </table> | | <u>DOSE</u> | <u>Frequency</u> | TYLENOL _____ | | Every 4 Hours | MOTRIN/ADVIL _____ | | Every 6 Hours |
| | <u>DOSE</u> | <u>Frequency</u> | | | | | | | | |
| TYLENOL _____ | | Every 4 Hours | | | | | | | | |
| MOTRIN/ADVIL _____ | | Every 6 Hours | | | | | | | | |
| | Signature and Date of Medical Examiner: _____ | | | | | | | | | |

Parent/Guardian Permission: I hereby give my consent for my child to receive the above medications:

Parent/Guardian Signature

Date