Annual Student Health Information Form

Please Print:

__________ __________ ________ ______ M ☐ F ☐
Student's Last Name First Birthdate Grade

Doctor: ____________________ Phone # __________

Dentist: ____________________ Phone # __________

Specialist: ____________________ Phone # __________

History/Medical Diagnosis - Please check <u>any</u> that apply and return to school office

☐ ADHD ☐ ***Asthma** ☐ Autism ☐ ***Diabetes** ☐ Heart/Lung ☐ ***Seizure Disorder** date of last seizure ______

☐ ***Allergies (specify)**

Drug Allergies	Food Allergies	Insect/Bee Allergies	Other Allergies

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

☐ Hearing Loss/Aids right / left ear ☐ Glasses/Contacts distance / near ☐ Anxiety

☐ Other Health Information ____________________

☐ Behavioral Concerns ____________________

☐ Concerns that might affect performance at school ____________________

☐ NO KNOWN HEALTH PROBLEMS

Please list medication given at home or school:

Medication__________ Reason__________ Dose______ Time(s)______

Medication__________ Reason__________ Dose______ Time(s)______

Medication__________ Reason__________ Dose______ Time(s)______

* **Any medications 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 **Archdiocese of Saint Louis 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 licensed doctor of medicine (MD), doctor of osteopathy (DO), or a physician's assistant (PA), or nurse practitioner (NP), working under a collaborative practice agreement with a licensed physician.

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 a physical 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 ________ BMI ______ BP ________ Pulse________

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____

Office Stamp	**PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD**