

Grade Entering _____



Physical Examination Form
School Year 2021-2022

This form must be returned to the school office by
Aug. 17, 2021.

List Dates (month / day / year)

Type of vaccine	1 st	2 nd	3 rd	4 th	5 th
DTaP/DTP (Diphtheria, Tetanus, Pertussis)					
DT					
Td					
Tdap (by 8 th Grade)					
OPV/IPV (polio)					
MMR (Measles, Mumps, Rubella)					
Measles					
Mumps					
Rubella					
HIB					
TB Test (Type & Result)					
Hepatitis B					
Varicella (Chicken Pox Vaccine)					
Other:					

Name: _____

Birth Date: _____ Sex: _____

Parent/Legal Guardian: _____

Physician's Name: _____

Physician's Phone #: _____

To Parent/Legal Guardian:

In accordance with the recommendations of the St. Louis Archdiocese Health Advisory Committee, all children are expected to have a complete physical examination upon entrance to K, 3rd grade, 6th grade, 9th grade, and all newly enrolled students who have not had a physical examination within the past 12 months.

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 Name: Ascension Catholic School

School Address: 238 Santa Maria Dr.
Chesterfield, MO 63005

School Phone: (636) 532-1151

School Fax: + 1 (636) 532-6502

Follow-Up Notes:

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 _____

	<p><u>PLEASE ATTACH A COPY OF THE CURRENT IMMUNIZATION RECORD</u></p>
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Office Stamp