Grade Entering ________________

List Dates (month / day / year)

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

Follow-Up Notes:

____

____

Physical Examination Form
School Year 2020-2021

This form must be returned to the school office by Aug. 17, 2020.

Name:____________________________________

Birth Date: ______________________ Sex: __________

Parent/Legal Guardian: ________________________________

Physician's Name: ____________________________________

Physician's Phone #: __________________________________

<u>To Parent/Legal Guardian:</u>
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. *<u>It is expected that each student have this form on file at school by the first day of school.</u>*

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

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____

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