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 2022-2023

This form must be returned to the school office by Aug. 16, 2022.

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

**APPENDIX 1** 3.1

## 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