ST. PAUL'S EPISCOPAL SCHOOL

MEDICAL EXAMINATION FORM

(Return To School By July 1)

NAME: _____ SEX: M / F GRADE: _____

DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ BP: _____

TO BE COMPLETED BY PHYSICIAN:
Please complete items noted below, and add comments as needed.

VISION: _____ _____ HEARING: _____ _____
RIGHT EYE LEFT EYE RIGHT EAR LEFT EAR

	NORMAL	ABNORMAL	COMMENTS
Eyes			
Ears			
Throat			
Neck & Thyroid			
Lungs & Chest			
Heart			
Abdomen			
Check for Hernia			
Extremities			
Skin			
Neurological			
Psychiatric			

SIGNIFICANT PAST HISTORY: _____

_____

ILLNESSES OR SPECIAL PROBLEMS: _____

_____

ALLERGIES: _____

_____

MEDICATION (IF A STUDENT IS ON MEDICATION TO BE GIVEN DURING SCHOOL, A MEDICATION AUTHORIZATION FORM MUST BE COMPLETED BY THE PHYSICIAN. PLEASE CONTACT THE SCHOOL, AND ONE WILL BE MAILED.):

_____

_____

THIS STUDENT MAY PARTICIPATE IN :

REGULAR PHYSICAL EDUCATION: YES / NO COMPETITIVE ATHLETIC TEAMS: YES / NO

Please attach a current Universal Certificate to this form,
or have physician complete the immunization record on the back.

MEDICAL EXAMINATION FORM
CONTINUED

NAME:_____

Please provide St. Paul's with a current Universal Certificate before the beginning of the school year. Immunizations mandated by the State of Louisiana: "4 DTaPs, 3 Polios, providing the last dose of each was administered on or after the 4th birthday (if the last dose was not administered on or after the 4th birthday, an additional dose is required), 2 MMR doses after age one, 3 HepB vaccines. 2 HepA, 2 Varicella (unless the child has had chicken pox)"

DTaP 1	_____	IPV 1	_____	MMR	_____
2	_____	2	_____		_____
3	_____	3	_____		
4	_____	Booster	_____	Hib	_____
Booster	_____		_____		_____
	_____				_____
		HepB	_____		_____
TB	_____		_____		
			_____	HepA	_____
Varicella	_____				_____
	_____	Meningococcal	_____		

Other _____

This patient was last examined by me on _____.

_____ _____

Print Physician's Name **Physician's Signature**

Address: _____

_____

Phone Number: _____