

List dates (month-day-year)

Type of vaccine	1st	2nd	3rd	4th	5th
<b>DTaP/DTP</b> (Diphtheria, Tetanus, Pertussis)					
<b>DT</b>					
<b>Td</b>					
<b>OPV/IPV</b> (polio)					
<b>MMR</b> (Measles, Mumps, Rubella)					
<b>Measles</b>					
<b>Mumps</b>					
<b>Rubella</b>					
<b>HIB</b>					
<b>TB Test</b> (type & result)					
<b>Hepatitis B</b>					
<b>Varicella</b> (chicken pox vaccine)					
<b>Other:</b>					

Follow-Up Notes:

### Physical Examination Form

**Student's 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 kindergarten, 3<sup>rd</sup> grade, 6<sup>th</sup> grade 9<sup>th</sup> 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:** \_\_\_\_\_ St. Paul School  
**School Address:** \_\_\_\_\_ 1235 Church Road  
**School Phone:** \_\_\_\_\_ St. Paul, MO 63366  
 Office - 636-978-1900 ext.2  
 Fax - 636-978-1944

**Medical History: (To be completed by parent)**

**Eyes:** Glasses \_\_\_ (reading \_\_\_ distance \_\_\_)  
Contacts \_\_\_ other

**Ears:** frequent infections \_\_\_  
tubes \_\_\_  
hearing difficulty  
(explain) \_\_\_  
hearing aid - right \_\_\_ left \_\_\_ wear at  
school \_\_\_

**Allergies:** (drugs, food, insects, pollens)  
Please list:

Has the allergy ever required emergency action?  
(explain)

**Asthma:** Yes \_\_\_ No \_\_\_  
Triggered by:

**Treatments/Medications:**

Diagnosed by physician (date): \_\_\_\_\_

**Seizures:** Yes \_\_\_ No \_\_\_  
Date of last seizure: \_\_\_\_\_  
Describe seizure:

**Medication:**

**Other Medications/Inhaler:**

Reasons for  
taking:

**Other Health Concerns:** diabetes \_\_\_ heart \_\_\_  
problem \_\_\_ bleeding \_\_\_ eating \_\_\_ sleeping \_\_\_  
bowel \_\_\_ bladder \_\_\_ bed wetting \_\_\_ dental \_\_\_  
skin \_\_\_ menstrual history \_\_\_ phobias(fears) \_\_\_  
blood pressure \_\_\_ orthopedic \_\_\_ neurologic \_\_\_  
head aches \_\_\_ blood disorder \_\_\_ lungs \_\_\_  
sickle cell anemia \_\_\_ TB exposure \_\_\_

**EXPLAIN:**

**Other illness, injury, or health problem that might  
affect performance at school:**

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