



St. Louis School Physician's Examination Form

(Copy of Immunizations must accompany this form)

Name of Student: _____ **Male / Female** **Date of Birth:** _____

Allergies: Medications: _____ **Foods:** _____ **Other:** _____

Medical History: _____

Pertinent Family History: _____

Significant Medical Conditions: (Check all that apply and explain)

Asthma () _____ Cardiac () _____

Diabetes () _____ GI Disorders () _____

Hearing Disorder () _____ Vision Disorder () _____

Respiratory Illness () _____ Neuromuscular Disorder () _____

Hypertension () _____ Genitourinary Disorder () _____

Skin Disorder () _____ Seizure Disorder () _____

Are there any special medical problems or chronic diseases which require restriction of activity, or medication that may affect his/her education? If so please specify _____

Physical Exam: **Height:** _____ **Weight:** _____ **B/P** _____ **Date of Exam:** _____

(Check if normal. If abnormal, please explain)

() Skin _____ () Heart _____ () Lungs _____

() HEENT _____ () Neurological _____ () Abdomen _____

() Oral/Dental _____ () Genitalia _____ () Extremities _____

Description of abnormalities: _____

VISION: Right Eye _____ Left Eye _____ **HEARING:** Right Ear _____ Left Ear _____ (Pass or Fail)

Type of Vision Correction if needed _____ History of tubes or Hearing Device _____

This student has the following problems that may impact his/her educational experience: (Please check all that apply):

Vision _____ **Hearing** _____ **Speech/language** _____ **Emotional/Social** _____ **Behavior** _____

Fine/Gross Motor _____ **Other** _____

Comments/Recommendations:

PHYSICIAN'S SIGNATURE: _____ *Please print name of Physician:* _____

Telephone Number of Physician's Office: _____