



St. Joseph's Catholic School
 202 South 10th Street
 Moorhead, MN 56560

HISTORY AND PHYSICAL EXAMINATION FORM

Student's Name (Last) _____ (First) _____ (Initial) ___ Sex M ___ F ___ Birth date _____
 Parent/Guardian _____ Phone (H) _____ (W) _____
 Grade _____ Age _____ Date _____ School (If known) _____ ID# _____

PARENT OR GUARDIAN: PLEASE COMPLETE THIS SECTION PRIOR TO SEEING PHYSICIAN

Health History — Enter Date			Current Health Concerns	
Allergies (Specify)	Mumps	At what age did your child:	(Specify)	
	Rheumatic Fever			
	Rubella			
Asthma	Seizures	Sit Alone		
Bone/Joint Problems (Specify)	Serious Accidents (Specify)			Walk Alone
				Talk Words
Ear/Hearing Problems	Surgery	Talk Sentences	Parent Signature: _____ Date: _____	
Chicken Pox	Other (Specify)	Bladder Train		
Diabetes		Bowel Train		
Heart Disease				
Measles				

PHYSICIAN: PLEASE COMPLETE THIS SECTION

Immunization History — Enter Month/Day/Year				Examination — Indicate Normal (N) or Abnormal (Ab) If Abnormal, Include Comments Below			
DTP/dT				N/Ab		N/Ab	
Polio				Skin/Lymph		Lungs	
Hepatitis B				Eyes		Abdomen	
MMR				Ears		Genito-urinary	
Varicella		Hib		Nose		Orthopedic	
Medical Exemption (Specify)	Conscientious Exemption (Specify)			Mouth		Scoliosis	
				Throat		Neurological	
				Neck		Speech	
				Heart		Other (Specify)	
Test — Indicate Normal (N) Abnormal (Ab) If Abnormal, Include Comments Below		Measurement Give Exact Value		1. Excellent Health — No restrictions No ___ Yes ___ 2. Physical activities should be restricted No ___ Yes ___ If Yes, Specify _____ 3. There is a condition that may result in an emergency No ___ Yes ___ If Yes, Specify _____ 4. There is a condition that may interfere with learning No ___ Yes ___ If Yes, Specify _____			
Tuberculin		Blood Pressure					
Hemoglobin/Hematocrit		Height					
Urine		Weight					
Lead		Vision: R 20/ _____ L 20/ _____ with glasses Yes No					
Other		Hearing: R _____ L _____ with hearing aid Yes No					

On-Going Therapies and Medications — Specify Type and Dose

Problems as Indicated Above (Include Restrictions Physical Activities)	Plans and Recommendations
Physician's Signature _____ Date of Examination _____ Phone _____ Physician's Name _____ Address _____ (Please Print or Type)	