

**PHYSICIAN TO COMPLETE
PHYSICAL FINDINGS:**

Growth Measurements:

Height _____ Weight _____

Dietary Restrictions: _____

Physiologic Measurements:

Temp: _____ Pulse _____ Respiration: _____

Blood Pressure: _____ Urinalysis: _____

Physical Exam:

General Appearance: _____

Skin: _____

Head: _____

Neck: _____

Eyes: _____

Vision Test: Both _____ Right _____ Left _____

Ears: _____

Hearing test: pass fail

Nose/Mouth/Throat: _____

Chest: _____

Abdomen: _____

Genitalia: _____

Back and Extremities: _____

Neurologic Exam: _____

Chronic conditions and treatment: _____

Should physical activity be restricted? Yes ___ No ___

If yes, specify degree _____

Other restrictions _____

Preferential seating: _____

Signature: _____

Date of examination: _____

Please Provide Copy of Immunization Record

VISITATION ACADEMY
3020 North Ballas Road
St. Louis, Missouri 63131
625-9100

HEALTH EXAMINATION RECORD

STUDENT'S NAME _____

GRADE _____ BIRTHDATE _____ AGE _____

PARENT/GUARDIAN _____

PHONE _____

PHYSICIAN _____

PHONE _____

The State of Missouri requires physical examinations upon entrance into school and at the beginning of Kindergarten, fourth, seventh and tenth grades. Therefore, only those students are receiving this form. **This form needs to be completed and returned to the school nurse no later than August 1.**

ALL DATES ON IMMUNIZATION AND BOOSTERS SHOULD HAVE MONTH, DAY, AND YEAR.

The form for the Missouri State High School Association must be completed for students participating in interscholastic athletics (including cheerleading) in grades 9-12. This form is available on our web site: www.visitationacademy.org in athletic section. This form must be returned before first tryout date. **This is an additional form.**

PARENTS, PLEASE COMPLETE PAGES 2 AND 3.

When was your child last seen by a dentist? _____
 Dental bridges/false teeth/braces _____
 List any serious illness, allergies, injuries, or surgery.

HISTORY OF IMMUNIZATIONS

MUST INDICATE <u>MONTH</u>, <u>DAY</u> and <u>YEAR</u> Please submit a copy of physician immunization record					
DTaP-Diphtheria-tetanus-pertussis					
Tdap					
Haemophilus b Conjugate Vaccine (Hib)					
Polio (IPV)					
Measles-Mumps-Rubella (MMR)					
Hepatitis B (HB)					
Varicella					
Prevnar					
Hepatitis A					

MEDICAL HISTORY: PARENTS to COMPLETE

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? _____

Asthma: Yes ___ No ___ Triggered by: _____
 Treatments/Medications: _____
 Please provide inhaler/physician order for administration.
Please provide Asthma Plan

Seizures: Yes ___ No ___ Date of last seizure: _____
 Describe seizure: _____
 Medication: _____

Other Medications: _____
 Reason for taking: _____

Other Health Concern: diabetes ___ Heart problem ___
 Bleeding ___ eating ___ sleeping ___ bowel ___ bladder ___
 Bed wetting ___ dental ___ skin ___ menstrual history ___
 Phobias _____ blood pressure _____ orthopedic _____
 Neurologic ___ headaches ___ blood disorder ___ lungs ___
 Sickle cell anemia ___ TB exposure ___
 Explain: _____

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