SAINT AGNES SCHOOL

PHYSICAL EXAMINATION FOR SCHOOL HEALTH RECORDS

Required annually for all students. You may use this form or one provided by the physician's office.
Please also complete the FARE Emergency Care Plan if allergies are present.

Name _____ Date & Place of Birth _____

Address _____

Father's Name _____ Mother"s Name _____

Physician to be called in an emergency _____ Phone _____

Blood Pressure _____ Height _____ Weight _____

Body Mass Index _____

Weight Status Category (BMI Percentile)

_____ Less than 5th _____ 5TH through 49th _____ 50TH through 84th

_____ 85th through 94th _____ 95th through 99th _____ 99th and higher

Nutrition _____ Tonsils _____ Nose _____

Teeth: Temporary _____ Permanent _____ Dental Referral _____

Nodes: Cervical _____ ORTHOPEDIC: Feet _____

Glands: Thyroid _____ Scoliosis Screening _____

Other (Specify) _____ Structural Defect _____

Heart _____ Lungs _____

Skin _____ Nervous System _____

Hernia _____ Speech _____

Health conditions school personnel should be aware of: include asthma, allergies, past operation, serious injuries, fractures, etc. _____

_____

_____

Has this child had any condition which required emergency treatment or hospitalization? If yes, for what? at what age? How long in hospital? _____

_____

(Continued next page)

Eyes: Acuity with glasses R _____ L _____

Acuity without glasses R_____ L_____

Ears: Hearing Loss R_____ L_____

Frequent Infections_____

Tubes Present _____ Since when_____

Other defects_____

IMMUNIZATION DATES

Polio	#1 _____	#2 _____	#3 _____	#4 _____	
DTP	#1 _____	#2 _____	#3 _____	#4 _____	#5 _____
Tdap	#1 _____				
Hib	#1 _____	#2 _____	#3 _____	#4 _____	
Measles	#1 _____	#2 _____			
Mumps	#1 _____	#2 _____			
Rubella	#1 _____	#2 _____			
Hepatitis B	#1 _____	#2 _____	#3 _____		
Varicella	#1 _____	#2 _____			
Prevner	#1 _____	#2 _____	#3 _____	#4 _____	

Other _____

MEDICAL HEALTH HISTORY DATES

Anemia _____ Heart Disease _____ Rheumatic Fever _____

Chicken Pox _____ Measles _____ Scarlet Fever _____

Diabetes _____ Mumps _____ Tuberculosis _____

Epilepsy _____ Nephritis _____ Whooping Cough _____

Hyperlipidernia _____ Pneumonia _____ Contact w/ TB _____

Seizures _____ Hypertension _____

Diabetes _____ Type 1 _____Type 2

Daily Medications _____

_____

IMMUNIZATIONS GIVEN TODAY_____

Signature of Physician _____

Date of Exam _____