

LITTLE SAINTS LEARNING CENTER
MEDICAL EXAMINATION FORM
(RETURN TO SCHOOL BY JULY 1, 2017)

NAME: _____ SEX: M/F GRADE: _____
DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ BP: _____

TO BE COMPLETED BY PHYSICIAN:

Please complete items noted below, and add comments as needed.

VISION: _____ HEARING: _____
RIGHT EYE LEFT EYE RIGHT EAR LEFT EAR

NORMAL

ABNORMAL

COMMENTS

Eyes			
Ears			
Throat			
Neck & Thyroid			
Lungs & Chest			
Heart			
Abdomen			
Check for Hernia			
Extremities			
Skin			
Neurological			
Psychiatric			

SIGNIFICANT PAST HISTORY: _____

ILLNESSES OR SPECIAL PROBLEMS: _____

ALLERGIES: _____

MEDICATION (IF A STUDENT IS ON MEDICATION TO BE GIVEN DURING SCHOOL, A MEDICATION AUTHORIZATION FORM MUST BE COMPLETED BY THE PHYSICIAN. PLEASE CONTACT THE SCHOOL, AND ONE WILL BE MAILED.):

THIS STUDENT MAY PARTICIPATE IN:

REGULAR PHYSICAL EDUCATION: YES / NO COMPETITIVE ATHLETIC TEAMS: YES / NO

Please attach a current Universal Certificate to this form,
or have physician complete the immunization record on the back.

Little Saints Learning Center
ST. PAUL'S EPISCOPAL SCHOOL
6249 Canal Blvd.
New Orleans, LA 70124
504-488-1319

**MEDICAL EXAMINATION FORM
CONTINUED**

NAME: _____

Please provide St. Paul's with a current Universal Certificate before the beginning of the school year. Immunizations mandated by the State of Louisiana: "4 DTaPs, 3 Polios, providing the last dose of each was administered on or after the 4th birthday (if the last dose was not administered on or after the 4th birthday, an additional dose is required), 2 MMR doses after age one, 3 Hepatitis B vaccines."

DTaP 1 _____	OPV 1 _____	MMR _____
2 _____	2 _____	_____
3 _____	3 _____	HIB _____
4 _____	Booster _____	_____
Booster _____	_____	_____
_____	HEP B _____	_____
TB _____	_____	

Varicella _____		
(PVC 7)		
Other _____		

This patient was last examined by me on _____.

Print Physician's Name

Address: _____

Physician's Signature

Phone Number: _____