MEDICAL EXAMINATION FORM

(RETURNED TO SCHOOL BY JULY 1, 2009)

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: _____________ RIGHT EYE _____________ LEFT EYE HEARING: __________ 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

IMMUNIZATION RECORDS TO BE COMPLETED ON THE REVERSE SIDE

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

MEDICAL EXAMINATION FORM
CONTINUED

NAME:____

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 ____________
2 ____________
3 ____________
4 ____________
Booster ____________
____
TB ____________

OPV 1 ____________
2 ____________
3 ____________
Booster ____________
____
HEP B ____________
____
____

MMR ___________
____
HIB ___________
____
____
____

Varicella _______
(PVC 7)
Other_______________________

This patient was last examined by me on ____________________.

____
Print Physician's Name

____
Physician's Signature

Address: ________________________
____

Phone Number: ___________________

TO BE COMPLETED BY PARENT:

In the interest of the health and well-being of your child, please describe any illness, allergies, physical condition or medication that have affected, or may affect, your child's general health or school participation and performance.
Please note: It is the parents' responsibility to keep the school apprised of new information, changes or needs throughout the school year.

____

____

MEDICAL CONSENT TO TREAT:
I hereby grant permission for the attending physician to proceed with any necessary medical or minor surgical treatment, x-ray examinations, or immunization for my child. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that the attending physician will make every reasonable attempt to contact me quickly and expeditiously. If said physician is unable to reach me, I authorize him/her to provide the treatment necessary for the well being of my child. I also grant school personnel permission to provide any needed emergency treatment to my child.

Permission is hereby granted to school personnel to administer the following over-the-counter medications: (circle)

Tylenol: Y/N Advil: Y/N Motrin: Y/N Pepto Bismol: Y/N Sudafed: Y/N Tylenol Cold: Y/N
____

____
Print Parent's/Guardian's Name

____
Parent's/Guardian's Signature