

# 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: \_\_\_\_\_ HEARING: \_\_\_\_\_  
RIGHT EYE LEFT EYE RIGHT EAR LEFT EAR  
NORMAL ABNORMAL COMMENTS

|                  | 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**

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 4<sup>th</sup> birthday (if the last dose was not administered on or after the 4<sup>th</sup> 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 _____ | Meningococcal _____ |           |
| (PVC 7)         |                     |           |
| Other _____     |                     |           |

This patient was last examined by me on \_\_\_\_\_.

\_\_\_\_\_  
**Print Physician's Name**  
Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**  
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**