



ST. PAUL'S EPISCOPAL SCHOOL MEDICAL EXAMINATION FORM

(Return To School By July 1)

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.**



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 HepB vaccines. 2 HepA, 2 Varicella (unless the child has had chicken pox)"

DTaP 1 _____	IPV 1 _____	MMR _____
2 _____	2 _____	_____
3 _____	3 _____	_____
4 _____	Booster _____	Hib _____
Booster _____	_____	_____
_____	HepB _____	_____
TB _____	_____	_____
_____	_____	HepA _____
Varicella _____	Meningococcal _____	_____
_____	_____	_____
Other _____	_____	_____

This patient was last examined by me on _____.

Print Physician's Name

Physician's Signature

Address:

Phone
Number:
