ST. PAUL'S EPISCOPAL SCHOOL
MEDICAL EXAMINATION FORM
(RETURN BY JULY 1st BEFORE START OF SCHOOL)

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.

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 _____
2 _____
3 _____
4 _____
Booster _____
_____
TB _____

OPV 1 _____
2 _____
3 _____
Booster _____
_____
HEP B _____
_____
_____

MMR _____
_____
HIB _____
_____
_____
_____

Varicella _____
(PVC 7)

Meningococcal_____

Other_____

This patient was last examined by me on _____.

_____ _____

Print Physician's Name **Physician's Signature**

Address: _____ Phone Number: _____

_____