Fax 513-732-1748

St. Louis School Physician's Examination Form

(Copy of Immunizations must accompany this form)

Name of Student: _____ **Male / Female** **Date of Birth:** _____ **Date of Exam** _____

Allergies: **Medications:** _____ **Foods:** _____ **Other:** _____

Medical History: _____

Pertinent Family History: _____

Significant Medical Conditions: **(Check all that apply and explain)**

Asthma ( ) _____ Cardiac ( ) _____ Diabetes ( ) _____
GI Disorders ( ) _____ Hearing Disorder ( ) _____ Vision Disorder ( ) _____
Respiratory Illness ( ) _____ Neuromuscular Disorder ( ) _____ Hypertension ( ) _____
Genitourinary Disorder ( ) _____ Skin Disorder ( ) _____ Seizure Disorder ( ) _____

Are there any special medical problems or chronic diseases which require restriction of activity, or medication that may affect his/her education? If so please specify _____

Physical Exam: **Height:** _____ **Weight:** _____ **B/P** _____ **Date of Exam:** _____

(Check if normal. If abnormal, please explain)

( ) Skin _____ ( ) Heart _____ ( ) Lungs _____

( ) HEENT _____ ( ) Neurological _____ ( ) Abdomen _____

( ) Oral/Dental _____ ( ) Genitalia _____ ( ) Extremities _____

VISION: **Right Eye** _____ **Left Eye** _____ **HEARING:** **Right Ear** _____ **Left Ear** _____ **(Pass or Fail)**

Type of Vision Correction if needed _____ History of tubes or Hearing Device _____

This student has the following problems that may impact his/her educational experience: (Please check all that apply):

Vision _____ **Hearing** _____ **Speech/language** _____ **Emotional/Social** _____ **Behavior** _____

Fine/Gross Motor _____ **Other** _____

** I have examined this child and found that he/she is in suitable condition for participation in group care.*

**This child has the age appropriate immunizations recommended by the Ohio Department of Health.*

OR

**This child is exempt from immunizations for the following reasons:* _____

PHYSICIAN'S SIGNATURE _____ **Print name of Physician** _____

Physician's address and Phone Number _____

_____

_____