Please Attach Immunization Records To this form

Dates MUST be listed as Month-Day-Year

Effective beginning the 2010-2011 school year the following **NEW** requirements will be implemented:

- Second dose of varicella (chickenpox vaccine for all children entering kindergarten. If the kindergarten child has had chickenpox disease, a licensed doctor of medicine will need to sign on the immunization form that the child has had chickenpox. The month-day-year must be noted.

- Tdap (Tetanus, diphtheria, and pertussis) vaccine will be required for all incoming eighth grade students if the child has completed the recommended childhood DTaP/DTP vaccination series and has not received a Td booster within the past two years.

Effective **July 1, 2010** the following NEW requirements will be implemented for ALL Pre-School children:

- Age appropriate pneumococcal conjugate vaccine (PCV) for **ALL** children attending Pre-School.

- For all Pre-School children who have had chickenpox disease, a licensed doctor of medicine will need to sign on the immunization form that the child has had chickenpox. The month-day-year must be noted.

Holy Spirit Catholic School
"Where the Spirit Guides You!"
3120 Parkwood Lane
Maryland Heights, MO 63043
Phone: 314-739-1934 Fax: 314-739-7703

Student' Name: _____

Birthdate: _____ Sex: _____

Parent/Legal Guardian:_____

Physician's Name: _____

Physician's Phone #: _____

To the Parent/Legal Guardian:

In accordance with the recommendations of the St. Louis Archdiocese Health Advisory Committee, all children are expected to have a complete physical examination upon entrance to Pre-School, Pre-Kindergarten, Kindergarten, Third Grade, and Sixth Grade. And all newly enrolled Students who have not had a physical examination within the past twelve months.

This form is provided for the convenience of your child's physician. At the time of the examination, please have your physician complete and sign this form. It is expected that each student have this form on file at school by the first day of school.

Medical History: (To be completed by parent)

Eyes: Glasses____ Reading____ Distance____ Contacts____

Other: _____

Ears: Frequent Infections: YES___ NO___ Tubes: YES___ NO___

Hearing difficulty: YES___ NO___ If yes, please explain _____

_____

Hearing Aid: Right Ear___ Left Ear___ Wear at school? YES___ NO___

Allergies: Please list _____

_____

Asthma: YES___ NO___ Diagnosed by physician _____/_____/_____
Month Day Year

Asthma medication please list; _____

_____ _____

Seizures: YES___ NO___ Date of last seizure: _____/_____/_____
Month Day Year

Please list medication for seizures: _____

_____ _____

Please list any other health concerns:

_____ _____

_____ _____

Please list any medication that your child is taking: _____

_____ _____

Child's Dentist's Name: _____

Dentist's phone number: _____

Form completed by (please print): _____

Physical Examination: (To be completed by Physician)

Growth Measurements:

Height _____ **Weight**_____

Physiologic Measurements:

Temperature: _____ **Pulse:** _____ **Respiration:** _____

Blood Pressure: _____

General Appearance: _____

Skin: _____

Head: _____

Neck: _____

Eyes: _____

Vision Test: Both Eyes_____

Right Eye _____

Left Eye _____

Hearing Test: Pass _____ Fail _____

Nose/Mouth/Throat: _____

Chest: _____

Abdomen: _____

Back & Extremities: _____

Neurological Examination: _____

Chronic conditions & treatments: _____

Should physical activity be restricted? YES____ NO____

Other restrictions: _____

Physician's Signature:_____

Date: _____