Immunization Record
List Dates (MM/DD/YY)

Type of Vaccine	1st	2nd	3rd	4th	5th
DTaP/DTP (Diphtheria, Tetanus, Pertussis)					
DT					
Td					
OPV/IPV (polio)					
MMR (Measles, Mumps, Rubella)					
Measles					
Mumps					
Rubella					
HIB					
TB Test (type 7 result)					
Hepatitis B					
Varicella (chicken pox vaccine)					
Hepatitis A* *not required as of 2001					

Follow Up Notes:

HOLY INFANT SCHOOL
Educating for Life's Journey

Physical Examination Form

Student's Name: _____

Date of Birth: _____ **Sex:** _____

Parent/Legal Guardian: _____

Physician's Name: _____

Physician's Number: _____

To Parent/Guardian:

All medications given at School require a physician's signature. If you would like your child to have Advil or Tylenol available to them, please be sure the following is filled out completely:

Patient may receive the following medication:

Tylenol _____ every 4 hours or

Motrin/Advil _____ every 6 hours for pain.

Allergic to food or medications: _____

Date: _____

Physician's Signature: _____

Parent Signature: _____

Holy Infant School
248 New Ballwin Road
Ballwin, MO 63021
636-227-0802; (fax) 636-227-9184

Medical History (To be completed by Parent)

Eyes: Glasses ____ (reading ____ distant) Contacts _____
Other**:** _____
Ears: Frequent infections: _____ Tubes _____
Hearing difficulties **(explain)** _____
Hearing aid: Right _____ Left _____ Wear at school _____

Allergies: (drugs, food, insects, pollens) _____
Food allergies require a **Food Allergy Action Plan** on file at School. Form can be downloaded from the website, www.holyinfantschool.org.
Asthma: Y _____ N _____ Triggered By :_____
Treatments/Medications: _____
Diagnosed by Physician (date): _____

Seizures: Y ____ N_____ Date of last seizure: _____
Describe Seizure: _____
Medication: _____
Other Medication/Inhaler: _____
_____
Reason for taking: _____

Other Health Concerns: diabetes _____ heart problem _____
bleeding _____ eating _____ sleeping _____ bowel _____
bladder _____ dental _____ skin _____ lungs _____
menstrual history _____ phobias (fears) _____ blood pressure _____ orthopedic _____ neurologic _____ head aches _____ blood disorder _____
sickle cell anemia _____ TB exposure _____
Explain: _____
Other illness, injury, or health problem that might affect performance at school: _____
_____

****Physical Examination: (To Be Completed by Physician)**

Growth Measurements: Height: _____ Weight: _____
Dietary Restrictions: _____

Physiologic Measurements: Temp: _____ Pulse _____
Respiration: _____ Blood Pressure: _____ Urinalysis: _____
Physical Exam:
General Appearance: _____
Skin: _____
Head: _____
Neck: _____
Eyes: _____
Vision Test: Both _____ **Right** _____ **Left** _____
Nose/Mouth/Throat: _____
Chest: _____
Abdomen: _____
Genitalia: _____
Back & Extremities: _____
Neurologic Exam: _____

Chronic conditions and treatment:
_____
_____
Should physical activity be restricted? Yes _____ **No** _____
If yes, specify degree _____
Other Restrictions _____
Preferential Seating _____

Physician's Signature: _____
Date: _____ **Date of Examination:** _____