

**PHYSICAL FORM FOR NEW STUDENTS ENTERING ST. JOHN SCHOOL**

A health examination is required for all first time entrants or all new students to the school. This information is required prior to the 1<sup>st</sup> day of school to be complete. For participation in sports, this physical examination is required each year to be completed after June 1, for the upcoming school year.

*(Physical and completed sports packet is required before student can practice and/or play any sport)*

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN Entering Grade \_\_\_\_\_ Year \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_  
First Middle Last MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
Street City Zip code

MOTHER'S NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
First Middle Last Home Work

FATHER'S NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
First Middle Last Home Work

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:  
NAME RELATIONSHIP TELEPHONE NUMBER(S)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_

PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHILD UP FROM THIS SCHOOL: \_\_\_\_\_

**Health History:** (Please explain any yes answers)

a) Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: \_\_\_\_\_ No: \_\_\_\_\_

b) Any known allergies; drug, environmental, food; describe: Yes: \_\_\_\_\_ No: \_\_\_\_\_

c) History of head injury, concussion, seizure, etc? Yes: \_\_\_\_\_ No: \_\_\_\_\_

d) History of any hospitalization or surgery; explain: Yes: \_\_\_\_\_ No: \_\_\_\_\_

e) Any spinal injuries or spinal defects: Yes: \_\_\_\_\_ No: \_\_\_\_\_

f) List all medications taken on a daily basis: \_\_\_\_\_

g) Note special concerns regarding participation in physical education, athletics or sports for you child: \_\_\_\_\_

h) Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**\*\*\*SPECIAL EMERGENCY REFERRAL INSTRUCTIONS\*\*\***

In the event that I cannot be reached or make arrangements for emergency medical attention at the time of illness/accident, I hereby authorize:

\_\_\_\_\_ to take my child to:  
Name of School

PHYSICIAN ADDRESS TELEPHONE #

HOSPITAL ADDRESS TELEPHONE #

Date of last Tetanus shot: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name (PLEASE PRINT)	Physical Assessment	Normal	Abnormal	Not Examined
Relevant Health Information	Present Age: yrs. mos.	General Appearance		
	Height (no shoes): inches (%)	Skin		
	Weight (light clothing): lbs. oz. (%)	Head		
	Hemoglobin or Hematocrit (opt):	Eyes:		
	Urnalysis (opt):	1) Reflex Test		
	Other:	2) Cover Test		
	Blood Pressure:	Ears		
	Pulse / Respiration:	Nose, Mouth, Pharynx, Teeth		
		Neck (thyroid/thyroid)		
		Heart		
		Lungs		
		Abdomen (include hernias)		
		Gonads		
		Orthopedic		
		Neurologic		

Explanation of Abnormal Findings:

IMMUNIZATION RECORD		month/day/year	
Immunizations	Dose 1	Dose 2	Dose 3
DPT/DTap/Td (diphtheria, pertussis, tetanus)			
Polio (OPV/IPV)			
MMR/M (Measles, Mumps, Rubella)			
Hib CV (Haemophilus)			
Hepatitis B			
Varicella			
Other			
Tuberculin Skin Test	Date:	Result:	
1 <sup>st</sup> screening	R	L	
2 <sup>nd</sup> screening	R	L	
Hearing Screening	at 25 dB	R	L
1 <sup>st</sup> Vision Screening	R20/	L-20/	
2 <sup>nd</sup> Vision Screening	R-20/	L-20/	
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