Follow-up Notes

Name: ____________________

Date of Birth: ____________________

Date	Grade	Scoliosis	Hearing	Vision	Dental	Height	Weight

Remarks: ____________________

Ritenour School District
Educational Excellence Since 1867

PHYSICAL FORM

Student Name: ____________________

Address: ____________________

Telephone Number: ____________________

Birthdate: ____________________

School: ____________________

Grade: ____________________ Sex: ____________________

To Parents:

In accordance with the recommendation of the St. Louis County Medical Society School Health Committee, all children are expected to have a complete health examination upon entrance into school and at the beginning of third, sixth and ninth grades.

This form is provided for the convenience of your child's physician.

Please return this form to school at the beginning of the school year indicated or initial enrollment.

Thank you for your cooperation.

Revised 09/12

Medical History (Please give dates of illness)

Chicken Pox: ______________________

Rheumatic Fever: ______________________

Any Other Diseases: ______________________

Please check those that apply to your child:

- ❑ Congenital Heart
- ❑ Tuberculosis Contact
- ❑ Frequent Colds
- ❑ Frequent Draining Ears
- ❑ Allergies

Other Pertinent History: ______________________

____

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Immunizations and Test (Please list day, month and year)

DPT #1 ______ #2 ______ #3 ______ #4 ______ #5 ______

DT ______________ Tdap ______________

Oral Polio—Trivalent #1 ______ #2 ______ #3 ______ #4 ______

IPV #1 ______ #2 ______ #3 ______ #4 ______

Rubeola Vaccine ______________________

Rubella Vaccine ______________________

Mumps Vaccine ______________________

MMR #1 ______________ MMR #2 ______________

HIB ______________________

HEP. B. #1 ______ #2 ______ #3 ______

Varicella #1 ______________ #2 ______________

Meningococcal/MCV4 ______________________

HPV #1 ______ #2 ______ #3 ______

HEP. A. #1 ______________ #2 ______________

PPD/Tine Test ______________ Results ______________

Vision Test: R-Eye ______________ L-Eye ______________

Urinalysys: Sugar ______________ Albumin ______________

Hearing Screening: Right Ear ______________ Left Ear ______________

Physical Examination (Please check all items examined)

T ______ P ______ R ______ BP ______

- ❑ Height
- ❑ Weight
- ❑ Nutrition
- ❑ Posture
- ❑ Nose
- ❑ T and A
- ❑ Eyes
- ❑ Ears
- ❑ Orthopedic
- ❑ Teeth and Gums
- ❑ Heart
- ❑ Tonsils Enlarged
- ❑ Lymph Glands
- ❑ Hernia
- ❑ Skin and Hair
- ❑ Lungs
- ❑ Throat
- ❑ Asthma

Medications (Please list all daily medications):

____

____

____

Details on positive findings: ______________________

____

____

Recommendations for correction or follow-up: ______________________

____

____

Should physical activity be restricted?

❑ Yes ❑ No

If yes, specify degree: ______________________

____

____

Doctor's Name (Please print): ______________________

Doctor's Signature: ______________________

Date: ______________________

Doctor's Address: ______________________

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