SAINT PAUL STUDENT MEDICAL EXAMINATION

Student's Full Name: _____ **Date:** _____

Phone: _____ Race: _____ Sex: ____

Address: _____ Birth date: _____ Age: _____

Birth place: _____

Father's name: _____ Mother's name: _____

SCHOOL YEAR:

STUDENTS LAST NAME:

STUDENTS FIRST NAME:

A. -HISTORY OF IMMUNIZATIONS, DISEASES, OPERATIONS, INJURIES-

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER
DIPHTHERIA			
PERTUSSIS (whooping cough)			
TETANIUS			
POLIO - ORAL			
POLIO - SALK			
MEASLES (Rubeola)			
SMALLPOX			
MUMPS			
GERMAN MEASLES (Rubella)			
OTHER( )			

	DATE	COMMENTS
CHICKENPOX		
SCARLET FEVER		
RHEUMATIC FEVER		
DIABETES		
ANEMIA (sickle cell)		
PARASITES (worms-type?)		
ALLERGY (type?)		
SEIZURES		
INJURY, FRACTURE		
OPERATION		
OTHER /ALLERGIES (specify)		

TUBERCULIN TEST (type) DATE: NEGATIVE: ☐ POSITIVE: ☐ X-RAY?

B. PHYSICAL EXAMINATION HEIGHT: WEIGHT: BLOOD PRESSURE:

CHECK (✓) ONLY	IF ABNORMAL OR		NEEDS FOLLOW UP	PHYSICIAN'S COMMENTS, FINDINGS, TESTS (use back side if needed)
NUTRITION				
NEUROLOGIC				
ORTHOPEDIC (incl. arches)				
SKIN, SCALP				
EYES	R	L		
VISUAL ACUITY	R	L		HAS GLASSES? CONTACT LENSES?
COLOR VISION				
EARS	R	L		
AUDITORY ACUITY	R	L		HAS HEARING AID?
SPEECH				
NOSE, THROAT				
MOUTH, TEETH				
GLANDS, THYROID				
HEART, LUNGS				
ABDOMEN				
GENITALIA				

C. LABORATORY (if needed) HEMOGLOBIN: GM., HEMATOCRIT: %, URINE: FECES:

D. PHYSICIAN CHECK (✓) BOX:	NO	YES	PHYSICIAN'S COMMENTS (use back side if needed)
EMOTIONAL/MENTAL/BEHAVIOR PROBLEM			
HEALTH HABITS PROBLEM			
PHYSICAL DISABILITY -- LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER DISABILITY			
SEIZURES			
ON MEDICATION ( )			
FOLLOW-UP RECOMMENDED			
FOLLOW-UP COMPLETED			

This student has completed the immunizations required by the Government: YES____ NO____ and in my opinion is free of any communicable disease and may be admitted to school YES ____ NO ____

Student's usual Physician: _____ Examining Physician: _____

Telephone#: _____ Telephone#: _____ License #: _____

In my opinion, this student is _____/ is not _____ physically qualified to participate in athletics ____, driver education ____, other _____ as of (date) _____

Examining Physician: _____ Telephone#: _____ License #: _____