

ST. LOUIS UNIFIED SCHOOL of Seventh-day Adventists
(To Be Filled Out by the Physician)

Student's Name: _____ Birth date: _____ Sex _____

Father's Name _____ Mother's Name _____

Do immunizations comply with State law? _____

Height: _____ Weight: _____ B.P. _____

I) General Health Information

Does child have asthma? Yes No

If yes, does child use a nebulizer? Yes No N/A

Does child wear glasses or contacts? Yes No

If yes, does the child need them in the classroom? Yes No N/A

Does Child have any other physical, medical or mental health conditions or known emotional concerns which would be helpful to the school in better understanding this child? Yes No if yes, please explain:

THE ABOVE NAMED PATIENT WAS EXAMINED ON _____ AND WAS FOUND TO BE IN GOOD PHYSICAL CONDITION AND MAY PARTICIPATE IN ALL ACTIVITIES.

IMMUNIZATIONS

******This form must be completed by a Physician. St. Louis Unified School must receive**

This form or an equivalent form from your Physician before the student's application can be reviewed for admission.

II) Past illnesses (please check those illnesses the student has had)

- Measles Scarlet Fever Heart disease
- Whooping cough Diphtheria Epilepsy
- Polio Chickenpox Frequent Colds (# per year _____)
- Rheumatic Fever Diabetes Hay fever Asthma

List any other serious illnesses, operations, or injuries, and age when occurred.

III) Has this student ever been around anyone known to have tuberculosis? Yes No

Has this student ever been skin tested for tuberculosis? Yes Year _____ No

Has he/she ever had a chest X-ray? Yes Year _____ No

When did the child last visit a dentist? Date _____

Has the student had his eyes examined? Yes Year _____ No

IV) Comment on students' habits:

a) How many hours sleep does he/she usually get per night? _____

b) Does he/she participate in outdoor activities? Not at all moderately frequently

c) Does he/she prefer reading or watching TV to outdoor activity? Yes No

d) Eating habits: Eats only at mealtime In between meals occasionally frequently

Please list any other items helpful to the school program in planning for the students' health:

1 _____

2 _____

3 _____

4 _____

5 _____

SIGNATURE OF PHYSICIAN

DATE

ADDRESS _____

TELEPHONE _____

*****Every student must have a physical every two years. ****A
COPY OF THE CHILD'S IMMUNIZATIONS MUST BE RECEIVED.**