



# St. Simon the Apostle Catholic School

11019 Mueller Road • St. Louis, MO 63123 • 314-842-0181 FAX 314-849-6355

## HEALTH FORM

Attention Parents:

In accordance with the recommendation of the St. Louis County Medical Society School Health Committee, all children are expected to have a complete physical examination upon entrance into school and at the beginning of the Kindergarten, Third Grade, and Sixth Grade. Evidence that the child has had this physical examination must be furnished to St. Simon the Apostle School before they will be allowed to attend.

This form is provided for the convenience of your child's physician. At the time of the exam, please have your physician complete this form, sign it and mail it directly to the school.

Thank you for your cooperation.

Student's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent or Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Allergies: (drugs, foods, insects, etc.): \_\_\_\_\_

TYPE OF VACCINE	1st	2nd	3rd	4th	5th	6th	
DTa P/DTP (Diphtheria, Tetanus, Pertussis)							
DT							
Td							
OPV/IPV (polio)							
MMR (Measles, Mumps, Rubella)							
HIB							
Hepatitis A							
Hepatitis B							
Varicella (Chicken Pox Vaccine)							
TB Test (type & result)							

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## I. Previous Medical History

Has the student ever been treated for any of the following health concerns (check if applicable):

- Headaches
- Stomach/bowel
- Bladder/urinary
- Skin conditions
- Chicken pox
- Surgeries
- Other illnesses/injuries

If yes, please explain: \_\_\_\_\_

## II. Physical Exam (to be completed by a physician):

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Vision: Both \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

Hearing Test: Pass/Fail Results: \_\_\_\_\_

Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

**IF MEDS ARE TO BE ADMINISTERED AT SCHOOL, PLEASE SUBMIT A CONSENT FORM.**

Comments on positive findings and/or anticipated activity restrictions:

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The above named patient was examined on \_\_\_\_\_ and was found to be in good physical condition and may participate in all activities.

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Physician Signature

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Date