



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: _____

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

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER	DATE	COMMENTS
DIPHTHERIA					
PERTUSSIS (whooping cough)					
TETANIUS					
POLIO - ORAL					
POLIO - SALK					
MEASLES (Rubeola)					
SMALLPOX					
MUMPS					
GERMAN MEASLES (Rubella)					
OTHER()					
TUBERCULIN TEST (type)	DATE:		NEGATIVE: <input type="checkbox"/> POSITIVE: <input type="checkbox"/> 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)

	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 #: _____

SCHOOL YEAR: _____

STUDENTS LAST NAME: _____

STUDENTS FIRST NAME: _____