TODDLER – EIGHTH GRADE STUDENT HEALTH FORM

(to be filled out by physician)

Student's Name_____ Sex M F Date of Birth ____/____/____
Last First MI

Father's Name_____ Phone Number_____
Last First MI

Mother's Name_____ Phone Number_____
Last First MI

Past History:

Has student been treated for Tuberculosis: YES NO Hepatitis: YES NO (type)_____

Does student have? (Please circle responses) Allergies Diabetes Seizure Disorder HIV Positive Status Asthma Heart Disease or Defect Severe Visual or Hearing Impairment

Please explain all circled responses: _____

_____

_____

Other pertinent past history or medical problems requiring continued treatment _____

_____

_____

Physical Exam

Date of Exam _____Height_____ Weight _____ BP _____ Pulse_____

For the following systems please circle normal or variant and explain any variable findings.

Vision	Normal	Variant	_____
Hearing	Normal	Variant	_____
Speech	Normal	Variant	_____
ENT	Normal	Variant	_____
Lungs	Normal	Variant	_____
Heart	Normal	Variant	_____
Extremities	Normal	Variant	_____

Does child take medications routinely? YES NO

If yes, please list medications/dosages_____

Does child require emergency medication? YES NO (i.e. asthma inhaler, bee sing kit)

Please list _____

Is medication self-administered? YES NO

Is there any other information the school should be aware of concerning the child's past or present health?

YES NO Please explain_____

Physician Signature_____

Physician Name (Please Print) _____

Physician Address _____

Physician Phone Number _____

Parents signing this form agree that the school and its employees and agents have no liability (and release them from same) for injuries, sickness or death of a child despite the disclosure to the school of the child's health status, except in the case of negligence. BOTH PARENTS OR GUARDIANS MUST SIGN

Father's Signature _____Date_____

Mother's Signature_____Date_____

Toddler – Eighth Grade Immunization Form

(to be completed by physician)

Phone Number: 636-458-6688 Fax Number: 636-458-6660

Student Name_____
Last First Middle

Sex Male___ Female___ Birth Date_____/_____/_____

IMMUNIZATION HISTORY
EXACT DATE (MONTH-DAY-YEAR) REQUIRED

INITIAL SERIES	1st	2nd	3rd	4th	5th
	Full Date M/D/Y	Full Date M/D/Y	Full Date M/D/Y	Full Date M/D/Y	Full Date M/D/Y
DtaP					
DT					
HiB					
POLIO (IPV)					
Measles Mumps Rubella (MMR)					
HEPATITIS A					
HEPATITIS B					
VARIVAX (Chicken pox)					
Prevnar					
Meningococcus					
Other					

Physician's Name_____
Please Print Name

Phone Number_____