



St. Ann Classical Academy

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PHYSICAL FORM

Name: _____ Birthdate: _____ Age: ____ Grade in Sept. ____

Allergies: _____

Will your child need: ____ Inhaler; ____ EpiPen ____; Benadryl; ____ Other medications (please list) _____ during the school day or to be kept in school for emergency use? (please check all that apply. The necessary paperwork will then be sent home for you and your healthcare provider to complete).

HEIGHT: _____ WEIGHT: _____ B/P: _____ SPECIAL CONCERNS: _____

Please list any significant illnesses, accidents, operations, congenital abnormalities, family history, activity restrictions, etc.

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***						Measles	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***						Mumps	Date: _____ Titer: _____
OTHER							
OTHER						Rubella	Date: _____ Titer: _____

Provisional admission attached—Date Granted: _____ Medical exemption attached Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

PHYSICAL FINDINGS (Please list any positive findings and treatment advised) DATE OF EXAM: _____

EENT _____

SPEECH _____ TEETH-MOUTH _____ NUTRITION _____ ABDOMEN _____ HERNIA _____

HEART/CARDIAC _____ LUNGS/PULMONARY _____

GU _____ GI _____ ENDOCRINE _____ THYROID _____

NERVOUS SYSTEM _____ LYMPH GLANDS _____ SKIN _____

ORTHOPEDIC (Feet) _____ (Posture) _____ (Structural) _____ (Other) _____

Signature of Examining Healthcare Provider (MD, DO, NP, PA) _____

OFFICE STAMP