



**LADUE SCHOOL DISTRICT  
HEALTH SERVICE FORM**

\_\_\_\_\_  
*Date of Examination*

\_\_\_\_\_  
*Signature of Examining Physician*

Please print or type:

Physician's Name: \_\_\_\_\_

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

Office Phone: \_\_\_\_\_

The school nurse is hereby granted permission to call the student's physician and to obtain medical information if the need arises.

\_\_\_\_\_  
*Parent/Guardian Signature*

**School:** \_\_\_\_\_

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

**Student Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Sex:** \_\_\_\_ **Grade:** \_\_\_\_

**Parent/Legal Guardian:**

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

\_\_\_\_\_  
**Home Phone:** \_\_\_\_\_

**To the Parent/Legal Guardian:**

The Ladue School District recommends that every child attending the public schools should have a complete physical examination at the beginning of kindergarten and grades 3, 6 and 9. It is also recommended that every new student file evidence of a physical examination with the Ladue School Health Service.

This form is furnished for the convenience of your physician. At the time of the examination, please have the physician complete this form and mail it directly to the school.

FOR THE PHYSICIAN TO COMPLETE – Immunizations and tests  
Please give month, day and year

	Basic Series	Latest Booster
* DPT		
* DT		
Tetanus		
* Polio	Salk	
	Sabin	
* Measles	Rubeola	
	Rubella	

\* Mumps \_\_\_\_\_

Varicella (chicken pox) \_\_\_\_\_

\* Hepatitis B \_\_\_\_\_

Latest Tuberculin Test: \_\_\_\_\_

\* Do these comply with Missouri State law? \_\_\_\_\_

Medical and Disease History (please check all that apply):

Asthma	<input type="checkbox"/>	Rubeola	<input type="checkbox"/>
Congenital Heart	<input type="checkbox"/>	Rubella	<input type="checkbox"/>
Convulsive Disorder	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>

Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Pertinent History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Findings and Recommendations:

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Is examination essentially normal? YES \_\_\_ NO \_\_\_

Please note any abnormal findings:

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Other \_\_\_\_\_

Is there any mental, emotional or physical condition for which this student is under care? YES \_\_\_ NO \_\_\_

If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

Scoliosis/Kyphosis? YES \_\_\_ NO \_\_\_

Is student on any routine medication? YES \_\_\_ NO \_\_\_

If yes, please specify:

\_\_\_\_\_

Please check YES or NO for any defect which limits student's participation in:

Classroom Activities YES \_\_\_ NO \_\_\_

Physical Activities YES \_\_\_ NO \_\_\_

Competitive Athletics YES \_\_\_ NO \_\_\_

Swimming YES \_\_\_ NO \_\_\_

If yes, please specify degree:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_