PRIVATE PHYSICIAN'S MEDICAL EXAMINATION REPORT

CITY OF ST. LOUIS - DIVISION OF HEALTH - SCHOOL HEALTH SERVICE

PS-8 (Rev. 05/06)

NAME ______ AGE ______

ADDRESS ______ TELEPHONE NUMBER ______

SCHOOL ______ GRADE ______ ROOM ______

IMMUNIZATIONS

DPT/DTAP	Tdap	ORAL POLIO	POLIO SHOT	MMR	MEASLES	HEPATITIS B	HIB	OTHER
					MUMPS			
	TD/DT					HEPATITIS A	PREVNAR	
			MENACTRA					
					RUBELLA	VARICELLA		
						CHICKENPOX VACCINE		

MEDICATION? ______ SPECIFY DOSE & FREQUENCY ______

PHYSICAL EXAMINATION

Height______ Weight______

Eyes______

Ears______

Teeth and Gums______

Nasal Passages______

Throat______

Skin and Scalp______

Speech Defect______

Mental______

Endocrine (Specify)______

Tuberculin Test: Type______ Date______

Heart______ Blood Pressure______ Pulse______

Lungs______ Respiration______

Orthopedic______

Abdominal______

Genitalia______

Allergy______

Nutrition G.F.P.______

Posture G.F.P.______

Others (Specify)______

Results: Positive ______ mm Negative______ mm

X-Ray: Date: ______ Result______

LABORATORY TESTS

(If indicated)

Hgb. Date:______

Urine, Date:______

Sickle Cell, Date:______

Other, Date:______

Hematocrit, Date:______

Blood Lead, Date:______ Levels:______

(To be tested annually from birth to the age of 6 years)

Is pupil able to carry a full program in school? ☐ Yes ☐ No

Have arrangements been made for necessary attention? ☐ Yes ☐ No

Is special seating in school recommended? ☐ Yes ☐ No

RECOMMENDATIONS AND REMARKS:

PLEASE RETURN TO THE SCHOOL NURSE WITHIN 30 DAYS

______ M.D.

SIGNATURE OF EXAMINING PHYSICIAN

______

DATE

______

PHYSICIAN'S NAME (PLEASE TYPE OR PRINT)

HEALTH HISTORY FORM

PS-7 (Rev. 02/11)

CITY OF ST. LOUIS - DIVISION OF HEALTH - SCHOOL HEALTH SERVICE
1520 MARKET, RM. 4051 ST. LOUIS, MO 63103
TELEPHONE # 657-1518 FAX # 612-5005

SCHOOL ______________________ GRADE ______ ROOM ______ RACE: ☐ White ☐ Black ☐ Indian ☐ Asian ☐ Hispanic ☐ Refugee/Immigrant

NAME	LAST	FIRST	MIDDLE	BIRTH DATE MONTH DAY YEAR	BIRTH WEIGHT
ADDRESS	NUMBER	STREET	ZIP CODE	☐ MALE ☐ FEMALE	SOCIAL SECURITY NO.
FATHER'S NAME	FIRST	LAST		OCCUPATION	TELEPHONE NUMBER
MOTHER'S NAME	FIRST	LAST	MAIDEN	OCCUPATION	TELEPHONE NUMBER
PRESENT MARRIAGE			GUARDIAN		

HOME TELEPHONE NUMBER	NUMBER OF CHILDREN IN FAMILY	NAME OF PRIMARY CARE PROVIDER	TELEPHONE NUMBER

HMO MEDICAID MC+	ID#	GROUP HEALTH PLAN ID#

IMMUNIZATIONS

DPT/DTAP	Tdap	ORAL POLIO	POLIO SHOT	MMR	MEASLES	HEPATITIS B	HIB	OTHER
					MUMPS			
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			MENACTRA					
					RUBELLA	VARICELLA		
						CHICKENPOX VACCINE		

HISTORY OF PAST ILLNESS AND INJURIES

If your child has had any of the following, please indicate the YEAR:

	EPILEPSY	BROKEN BONES	DIABETES	FREQUENT COLDS AND SORE THROAT	CHICKEN POX DISEASE	SCARLET FEVER	TUBERCULOSIS	RHEUMATIC FEVER
YEAR								
LIST	EAR INFECTIONS	OPERATIONS	ASTHMA	OTHER ILLNESSES	ALLERGIES	BEHAVIOR PROBLEMS	DAILY MEDICATIONS	
YEAR					TYPE:	TYPE:	TYPE:	

COMMENTS REGARDING ANY OF THE ABOVE CONDITIONS OR ANY SPECIAL PROBLEMS: ______________________

____

DOES CHILD HAVE SPECIAL HEALTH CARE NEEDS? ☐ NO ☐ YES TYPE: ______________________

FAMILY HISTORY

CIRCLE DISEASE AND GIVE NAME AND RELATIONSHIP TO CHILD:

TUBERCULOSIS	CARDIOLOGY DISORDERS	MENTAL DISORDERS	ENDOCRINE	CANCER	DIABETES	ASTHMA	OTHER ILLNESSES

HAS YOUR CHILD ATTENDED ANY OTHER ST. LOUIS PUBLIC, CHARTER, PAROCHIAL OR HEAD START SCHOOL? ☐ NO ☐ YES WHERE: ______________

School ______________________ Date __________ School ______________________ Date __________

School ______________________ Date __________ School ______________________ Date __________

Signature ______________________________________ Date ______________________

Asthma Action Plan

General Information:

- Name ____________________
- Emergency contact ____________________ Phone numbers ____________________
- Physician/healthcare provider ____________________ Phone numbers ____________________
- Physician signature ____________________ Date ____________________

Severity Classification

- O Intermittent
- O Moderate Persistent
- O Mild Persistent
- O Severe Persistent

Triggers

- O Colds
- O Smoke
- O Weather
- O Exercise
- O Dust
- O Air Pollution
- O Animals
- O Food
- O Other ____________________

Exercise

1. Premedication (how much and when) ____________________
2. Exercise modifications ____________________

Green Zone: Doing Well

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Peak Flow Meter

More than 80% of personal best or ____________

Peak Flow Meter Personal Best =

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or

____________ to ____________

Contact physician if using quick relief more than 2 times per week.

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief medication every 4 hours for 1 to 2 days.
- O Change your long-term control medicine by ____________________
- O Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief treatment again.
- O Change your long-term control medicine by ____________________
- O Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or

____________ to ____________

Ambulance/Emergency Phone Number:

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

- O Still in the red zone after 15 minutes.
- O You have not been able to reach your physician/healthcare provider for help.
- O ____________________

Call an ambulance immediately if the following danger signs are present:

- O Trouble walking/talking due to shortness of breath.
- O Lips or fingernails are blue.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: __________

PLACE PICTURE HERE

Allergy to: ______________________

Weight: __________ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: ______________________

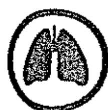
THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG Short of breath, wheezing, repetitive cough

HEART Pale, blue, faint, weak pulse, dizzy

THROAT Tight, hoarse, trouble breathing/ swallowing

MOUTH Significant swelling of the tongue and/or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy/runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if wheezing): ______________________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE