



Saint Joseph Notre Dame High School
Medical/Physical Report

*Please note: This form cannot be filled out or turned in until AFTER July 1

Student Name: _____ [] Male [] Female

Grade Level _____ Date of Birth: _____ Place of Birth: _____

HEALTH DATA (to be filled out by parents and physician)

I. IMMUNIZATIONS AND TESTS (Booster/Tuberculin) (dates to be filled out by physician)

Polio: _____ Smallpox: _____
Measles Vaccine (MMR) _____ DPT: _____
Tuberculin: Pos. _____ Neg. _____ Chest X-Ray: _____
Tetanus: _____ Mumps: _____

II. HEALTH HISTORY (check where appropriate)

[] Allergy [] Frequent Leg/Joint Pain [] Rubella
[] Allergy to Drugs [] Frequent Nosebleeds [] Scarlet Fever
[] Appendectomy [] Heart Disease [] Shortness of Breath
[] Cerebral Palsy [] Hernia [] Sinus Trouble
[] Concussion [] Kidney Disease [] Speech Difficulty
[] Defective Vision [] Lameness [] Tires Easily
[] Diabetes [] Mumps [] Tonsillectomy
[] Dizziness/Blackouts [] Nervousness [] Tuberculosis
[] Ear Trouble [] Persistent Cough
[] Hearing Loss [] Poliomyelitis
[] Epilepsy [] Recurrent Boils
[] Frequent Headaches [] Rheumatic Fever

DENTAL HISTORY

[] False Teeth
[] Orthodontia

List any other serious illness, operation or injury and the age when this happened:

Has your son/daughter ever had any contact with tuberculosis? [] Yes [] No If yes, when? _____

Has your son/daughter ever been advised not to participate in competitive athletics? If yes, please specify. _____

Is your student currently under a physician's care? If so, please specify _____

III. ADJUSTMENT (to be filled out by parent)

Do you feel that your son or daughter has problems of adjustment to friends, to school or to family that should be brought to the attention of your physician or school personnel?

IV. PROFESSIONAL HEALTH CARE (to be filled out by parent)

Name of Physician: _____ Date of last visit: _____

Name of Dentist: _____ Date of last visit: _____

V. STUDENT MEDICAL STATS

Height _____ Weight _____ Vision _____ Urine _____ Hemoglobin _____

Pulse Rate:

At rest: _____ After exercise: _____ Recovery Rate (min.) _____ B.P. _____

VI. GENERAL APPEARANCE

Head, neck (*e.g. masses, thyroid*) _____

EENT (*e.g. sinuses, tonsils*) _____

Mouth (*e.g. condition of teeth, gums*) _____

Chest (*e.g. asymmetry, breasts*) _____

Heart (*e.g. rate, rhythm, murmur*) _____

Lungs _____

Abdomen (*e.g. masses, hernia*) _____

Genitalia _____

Extremities _____

Skin _____

Neurological _____

Summary of Findings _____

Does the student have any vision or hearing problem for which the school could not compensate by proper seating or other action? If yes, please explain.

Is the student subject to any condition for which the school should make special preparation? (*e.g. epilepsy, fainting, heart disease*) If yes, please explain.

Is there any emotional, mental, or physical condition for which this student should remain under periodic medical observation? If yes, please explain.

VII. RECOMMENDATIONS AND SIGNATURES

Yes, in my professional opinion, this student is healthy enough to participate in all school activities and inter-school competitive sports. **Initial here:** _____

OR

No, in my professional opinion, I suggest the following modifications be made to this student's activities (include duration of modifications) If the responsible person from the school would like to call me, I believe it would be beneficial to discuss this further.

Initial here: _____ **Daytime Phone Number:(_____)** _____

Physician's Signature

Date

Parent's Signature

Date