



Saint Joseph Notre Dame High School Medical/Physical Report

*Please note: This form cannot be filled out or turned in until AFTER June 11

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)

MMR _____ Varivax (Chicken Pox) _____
TdaP _____ Polio _____
Meningococcal _____ Hepatitis B _____
PPD result _____ date _____ CXR result _____

II. HEALTH HISTORY (check where appropriate)

Grid of health history items with checkboxes: Allergy/Anaphylaxis, Heat Stroke, Epilepsy, Allergy to Drugs, Mumps, Frequent Headaches, Appendectomy, Dizziness/Blackouts, Heart Disease, Cerebral Palsy, Frequent Nosebleeds, Sinus Trouble, Concussion, Rubella, Hernia, Glasses/Contacts, Poliomyelitis, Tires Easily, Kidney Disease, Recurrent Boils, Tonsillectomy, Diabetes, Rheumatic Fever, Tuberculosis, Ear Trouble, Shortness of Breath, Family History of exercise related death, Asthma/Persistent Cough, Leg/Joint Pain or Injury, Hearing Loss, Speech Difficulty

DENTAL HISTORY _____ False Teeth _____ Orthodontia

If yes to above, give details _____

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: _____

(over)

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 *(to be filled out by physician)*

Height _____ Weight _____ Vision _____ Urine _____ Hemoglobin _____

Pulse Rate: _____ 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. asses, 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:** _____

Physicians Signature _____ **Date** _____

Parents Signature _____ **Date** _____