Magnificat High School
Medical Exam

Year of Graduation: _____

Name: _____
Last *First* *Middle*

Date of Birth: _____ Home Phone Number: _____

_____
Address *City* *Zip*

Previous School: _____ School Phone Number: _____

This completed two-sided medical exam form is due by July 8 to the Office of Student Life.
The Sports Physical Form for athletics DOES NOT serve as a replacement for this form.
Physical exams must have been completed within one year of the first day of the new school year.
Please complete proper paperwork from previous school,
allowing your daughter's health records to follow her to Magnificat High School.

Medical History of Child

Parent/Guardian completion:

Peanut/tree nut allergy: Type of nut: _____

Description of reaction: _____

Treatment for reaction: _____

Year of allergy diagnosis: _____

Stinging insect allergy: Type of insect: _____

Description of reaction: _____

Treatment for reaction: _____

Year of allergy diagnosis: _____

Any other known allergies: _____

Description of reaction: _____

Treatment for reaction: _____

Please contact Adam Wilson, Executive Chef at 440-331-1572 ext. 243 with any questions or concerns regarding food allergies or dietary restrictions.

Asthma: ___ Yes ____ No **Exercise Induced Asthma:** ____ Yes ____ No

Asthma treatment: _____

Previous surgical procedures: _____

Daily medications; dosage and frequency: _____

Other significant health information: _____

Menstrual history/difficulties: _____

_____

Signature of Parent/Gardian: ***Date***

Student Name **Date of Birth**

Immunization History

Physician/physician office completion. *Please include* ***Month, Date, and Year*** *of each immunization.*

DtaP/DPT/DT: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ Tdap: _____ Td: _____

Polio: 1. _____ 2. _____ 3. _____ 4. _____

MMR: 1. _____ 2. _____

Hepatitis B: 1. _____ 2. _____ 3. _____

Addition non-required vaccines:

Varicella: 1. _____ 2. _____

Meningococcal: 1. _____ 2. _____

HPV: 1. _____ 2. _____ 3. _____

Hepatitis A: 1. _____ 2. _____

Pneumococcal: 1. _____

Medical Examination

Height: _____ Weight: _____ BMI: _____ BMI%: _____

B.P.: _____ Pulse: _____ Respirations: _____

Allergies: _____

Eyes: _____ Vision: R: 20/ _____ L: 20/ _____ Glasses _____ Contacts _____

Ears: _____ Hearing Test: Type: _____ R: _____ L: _____

Nose: _____ Any vision, speech, or hearing difficulty: _____

Mouth: _____ Lungs: _____

Throat: _____ Abdomen: _____

Nutrition: _____ Skin: _____

Neck/Thyroid: _____ Orthopedic: _____

Heart/Murmurs: _____ Posture: _____

Nervous System: _____

Any current/prior physical limitation: ____ No ____ Yes: _____

Your signature below agrees that based upon the physical exam and medical history this student may participate in a vigorous physical education class.

If limitations are advised, please specify: _____

_____

Physician Signature ***Date of the Exam*** ***Office Phone Number***