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____
Meningoccocal _____ Hepatitis B _____
PPD result_____ date _____CXR result _____

_____

II. HEALTH HISTORY *(check where appropriate)*

_____ 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**