CHAMINADE HIGH SCHOOL PHYSICAL EXAMINATION RECORD 2011-2012 FRESHMAN YEAR

Entry into Chaminade High School is prohibited unless this certificate is on file the first day of school. EACH ITEM MUST BE SPECIFICALLY FILLED IN.

NAME ______________ ADDRESS ______________ HOME PHONE ______________

PERSON TO CONTACT IN EMERGENCY ______________ RELATIONSHIP TO STUDENT ______________ EMERGENCY PHONE ______________

1. BP ________ Pulse________
2. Height ________ Weight ________
   Body Mass Index: ________ ________ . ________
   Weight Status Category (BMI Percentile) Check one:
   less than 5th 5th-49th 50th-84th
   85th-94th 95th-98th 99th and higher
3. Urine (current & required)
   Sugar _ *Albumin* ________
4. Heart ________
5. Lungs ________
6. Eyes R ________ L ________
7. Visual Diagnosis ________
8. Ears ________
9. Nose ________
10. Throat ________
11. Tonsils ________
12. Teeth and gums________
13. Skin________
14. Glands (cervical, thyroid, other) ________
15. Nervous system ________
16. Hernia ________
17. Genitourinary ________
18. Abdomen ________
19. Scoliosis (defect found) ________
20. Additional Vaccines + Dates________

Significant Medical History and Allergies________

Recommendations:________

The above-named student may participate in interscholastic sports (list exceptions) ________

Certificate of Immunization

Date of Birth: ___/___/________

In accordance with NYS Immunization Law, entry into Chaminade requires that a Certificate of Immunization, signed by a physician listing ***exact dates*** be on file by the ***first day of school***.

REQUIRED IMMUNIZATION ***Please enter exact MONTH, DAY and YEAR of each immunization (booster).***

DPT-DT (3 required): ___/___/___ ___/___/___ ___/___/___ ___/___/________

Tdap (required) ___/___/________

Polio (3 required): ___/___/___ ___/___/___ ___/___/___ ___/___/________

MMR (required) I. ____/____/___ II. ____/____/____

Hepatitis B (Vaccine) I. ____/___/____ II. ___/___/___ III. ___/___/___ (Mandatory) 3 required

Chicken Pox (Vaccine or disease) (required). ___/___/___ Last TB Screening: _____/___/_____

Other Vaccines: Type + Date ________

Office Stamp ________M.D. Signature________M.D.
(Family Physician)

Date of examination________ Signature________M.D.
(School Physician)

Below to be completed by a Parent/Guardian or Physician

1. Has this student had any serious illness, injury or operation? Please specify and give year of occurrence:

2. Has or does this student receive any medication on a regular basis? Please specify:
*(Give name of medication, frequency, and if taken during school hours. Please consult the **School Handbook** for medication consent procedures.)*

3. Does this student have asthma; diabetes; epilepsy; seizure disorder; a heart, kidney, or orthopedic condition? Please specify:

4. Does this student have any allergies? Please specify:____________________

Parent Signature ____________________ Date ____________________

OR

Physician's Signature ____________________ Date ____________________

Is there any other information that you think the health office should know?