

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 RELATIONSHIP EMERGENCY IN EMERGENCY TO STUDENT PHONE

- 1. BP Pulse
2. Height Weight Body Mass Index: Weight Status Category (BMI Percentile) Check one:
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 Medication History and Allergies

Recommendations:

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

Office Stamp M.D. Signature (Family Physician) M.D.

Date of examination Signature (School Physician) M.D.

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?