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 1, 2021 to the Main Office. Please note: the sports physical 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 AVI Executive Chef at 440-331-1572 ext. 243 or ebartuskaite@maghs.org 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: ____________________

Students are permitted to carry and self-administer over-the-counter medication at the discretion of their parents/guardians. Over-the-counter medications must be in their original containers. The sharing of such medication with other students is strictly prohibited.

____

Signature of Parent/Guardian: 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. ________

Varicella: 1. ________ 2.________

MCV4: 1. ________ 2.________

Addition non-required vaccines:

HPV: 1. ________ 2.________3. ________

Hepatitis A: 1. ________ 2.________

Pneumococcal: 1. ________ 2.________3. ________ 4. ________

Medical Examination

Height: _______Weight:_______ BMI%:___________BMI%: ___________

BP:___________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*