THIS MUST BE RETURNED TO THE MAIN OFFICE BY WEDNESDAY AUGUST 6, 2024

MATER DEI HIGH SCHOOL

PHYSICAL EXAMINATION RECORD

(To be completed by your doctor)

NAME_____ GRADE_____

ADDRESS_____CITY_____TELEPHONE#_____-_____-_____

DATE OF BIRTH_____/_____/_____ SEX_____

FAMILY PHYSICIAN_____ PHYSICIAN PHONE# _____-_____-_____

ALLERGIES_____

PHYSICAL EXAMINATION

(CODE: No Defect-0; Defect– Note)

Height_____Weight_____

Eyes:
(indicate if with/without glasses/contacts)
Right: _____ Left: _____

Ears:
Right: _____ Left: _____

Teeth _____
Caries _____

Nose_____

Throat_____

Lymph Nodes _____

Thyroid _____

Heart _____

Blood Pressure_____

Lungs _____

Abdomen _____

Hernia _____

Orthopedic Impairments_____

_____

Posture/Scoliosis_____

Nutrition _____

Skin_____

Nervous Symptoms_____

Menstrual History _____

Anno-rectal_____

External Genitals_____

General Condition_____

History of severe illnesses, injuries, or surgeries_____

FULL RECORD OF REQUIRED IMMUNIZATIONS

Month/Day/Year

DPT/DTap 1._____
2._____
3._____
4._____
5._____
6._____

Td 1._____
2._____

Tdap 1._____

Polio Vaccine (circle type)
OPV/IPV 1. _____
OPV/IPV 2. _____
OPV/IPV 3. _____
OPV/IPV 4. _____
OPV/IPV 5. _____
OPV/IPV 6. _____

Meningococcal (circle type)
MCV4/MPSV4 1. _____
MCV4/MPSV4 2. _____

HPV 1._____
2._____

MMR 1._____
2._____

Hepatitas A 1._____
2. _____

Hepatitas B 1._____
2._____
3._____

Hib 1._____
2._____
3._____
4._____

Prevnar 1._____
2._____
3._____
4._____

Varicella 1._____
2._____
(or date of disease)_____

Other 1._____
2._____

TESTS

A) Tuberculin: Type_____ Date_____ Negative___ Positive___ X-ray___
B) Lead Poisoning: Yes____ No____ Results_____
C) Urinalysis: Date_____ Results_____
D) Other_____

PHYSICIAN'S RECOMMENDATIONS

I recommend medical or dental attention to the following conditions:_____
Student is physically fit to participate in physical education? Yes_____ No_____ Date_____
Signature of Physician_____ Printed Name of Physician_____

(continued on back)

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MATER DEI HIGH SCHOOL

PAST HEALTH HISTORY

(To be completed by parent)

NAME_____ BIRTH DATE_______________

GRADE_____ SEX_____

ADDRESS_____CITY_____TELEPHONE#_____-_____-_____

NUMBER OF CHILDREN IN FAMILY_____ FAMILY PHYSICIAN NAME_____

FAMILY DENTIST NAME _____

A. GENERAL HEALTH

Height_____Weight_____

1. Eye symptoms_____

   Wears glasses/contacts Yes_____ No_____

   Age when received glasses_____

2. Ear symptoms_____

   Hearing_____

   Earraches _____

   Dishcharging ear_____

3. Colds, sore throat, etc_____

4. High fever_____

5. Fainting spells_____

6. Convulsions_____

7. Dental Problems_____ _____

8. Speech difficulty_____

9. Medications (names)_____

   Are they taken regulary?_____

   When?_____

_____

10. Diabetes_____

    Is there diabetes in family?_____

E. DISEASE AND CONDITIONS (Date)

(Chicken pox date required if not vaccinated)

Whooping Cough	_____
Chicken pox	_____
Measles-Rubeola	_____
Rubella (3 day)	_____
Mumps	_____
Scarlet Fever	_____
Strep Throat	_____
Rheumatic Fever	_____
Mononucleosis	_____
Poliomyelitis	_____
Bronchitis	_____
Pneumonia	_____
Hepatitis	_____
Osgoode-Schlatter	_____
Epilepsy	_____
Nose Bleeds	_____
Asthma	_____
Eczema	_____

Is there any condition present which should be considered in planning your child's program at school?

_____

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