

Villa Maria Academy High School

Freshman Physical Form

Name of Student: _____ Date of Exam: ___/___/___

Date of Birth: ___/___/___

Address: _____ City: _____ State: ___ Zip: _____

IMMUNIZATIONS

You may attach your student's immunization record to this document.

*Immunizations must be updated and are required before entrance to school. Students may not enter school until the physical examination form is complete and on file at school.

| Vaccine (doses) | Enter month, day & year (please give exact dates) each immunization was given | | | | |
|--|---|---|------------------------------------|---|---|
| DTaP, DTP, Td or DT | 1 | 2 | 3 | 4 | 5 |
| Tdap (Tetanus, Diphtheria & Acellular Pertussis) | 1 | 2 | 3 | 4 | 5 |
| Polio | 1 | 2 | 3 | 4 | 5 |
| Hepatitis B | 1 | 2 | 3 | 4 | 5 |
| MMR (Measles-Mumps-Rubella) | 1 | 2 | | | |
| Varicella (Vaccine or Disease) | 1 | 2 | Varicella disease diagnosed by MD: | | |
| MCV (Meningococcal) | 1 | 2 | | | |
| Hepatitis A | 1 | 2 | 3 | | |

Age appropriate dose of MCV and Tdap are required for entry into 9th grade.

HEALTH HISTORY (Give Dates, if known)

Allergy _____ Epi-pen Yes or No _____ Behavioral Health _____

Asthma _____ Inhaler Yes or No _____ Diabetes _____

Concussion _____ Heart Disease _____

Give significant details of child's medical history, including serious illness, operations, accidents, etc. _____

Height: _____ Weight: _____ BMI: _____ B/P: _____ Pulse: _____ RR: _____

| | | | | | | | | |
|-------------------|--------|----------|----------------|--------|----------|------------|--------|----------|
| | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
| Emotional Status | () | () | Teeth | () | () | Posture | () | () |
| General Nutrition | () | () | Glands | () | () | Scoliosis: | () | |
| Skin | () | () | Heart | () | () | | | |
| Eyes | () | () | Lungs | () | () | | | |
| Glasses/ | R: | L: | Abdomen | () | () | | | |
| Ears | () | () | Neuro-muscular | () | () | | | |
| Hearing | () | () | Speech | () | () | | | |
| Nose & Throat | () | () | Skeleton | () | () | | | |

Is child under treatment? Yes () No () Should this child have restrictions with physical education or sports activities? Yes () No ()

Medical Diagnosis _____

Medications prescribed _____

Signature of Physician _____

Telephone _____

Please return this form by August 15
Villa Maria Academy High School
Attention: School Nurse
370 Central Avenue
Malvern, PA 19355