

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. _____	MMR 1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	Hepatitis A 1. _____
5. _____	2. _____
6. _____	Hepatitis B 1. _____
Td 1. _____	2. _____
2. _____	3. _____
Tdap 1. _____	Hib 1. _____
Polio Vaccine (circle type)	2. _____
OPV/IPV 1. _____	3. _____
OPV/IPV 2. _____	4. _____
OPV/IPV 3. _____	Pprevnar 1. _____
OPV/IPV 4. _____	2. _____
OPV/IPV 5. _____	3. _____
OPV/IPV 6. _____	4. _____
Meningococcal (circle type)	Varicella 1. _____
MCV4/MPSV4 1. _____	2. _____
MCV4/MPSV4 2. _____	(or date of disease) _____
HPV 1. _____	Other 1. _____
2. _____	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 _____

THIS MUST BE RETURNED TO THE MAIN OFFICE BY WEDNESDAY AUGUST 5, 2026

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 regularly? _____

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?

PLEASE RETURN TO THE MAIN OFFICE AT MATER DEI