Saint Dominic Academy
EMPOWERING WOMEN FOR LEADERSHIP SINCE 1878

MEDICAL HISTORY FORM: PLEASE COMPLETE BETWEEN JULY 1 AND AUGUST 30.

NAME _____ DATE OFBIRTH _____

ADDRESS _____

_____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

PARENT/GUARDIAN NOTE

A physical examination, including Scoliosis Screening, is required for the Freshmen and Junior classes. This is in compliance with certain state regulations and is necessary for the student to take part in interscholastic athletics, intramural sports and regular gym activities.

STUDENT PAST MEDICAL HISTORY (To be completed by parent/guardian)

Has the student been diagnosed with any of the following? (Circle any appropriate answer)

Asthma	When? _____	Diabetes	When? _____
Chickenpox	When? _____	Hepatitis	When? _____
Heart Disease	When? _____	Rheumatic Fever	When? _____
Seizure Disorder	When? _____	Any chronic illness	When? _____

Comments _____

_____

I give my consent to the school nurse at St. Dominic Academy to administer Acetaminophen (Tylenol), regular strength, 1 or 2 tablets (circle one), to my daughter/patient for the relief of minor discomfort and/or fever.

_____ _____

PRINT PARENT NAME PARENT SIGNATURE

_____ _____

PHYSICIAN SIGNATURE PHYSICIAN PRACTICE STAMP

IMMUNIZATIONS

Please be specific: MONTH, DAY AND YEAR must be included. SERIES COMPLETE OR IMMUNIZED is not acceptable (CHAPTER 14, NJ STATE LAW). A DT or Td is recommended if one has not been received within 10 years.

VACCINE TYPE	DISEASE DATE	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE	6TH DOSE
DTP							
OPV							
MMR							
Measles							
Mumps							
Rubella							
Hepatitis B							
Hib							
DT or Td (Circle)							

TB SCREENING (Mantoux Test)	Date	Date	Date	Chest X-Ray Date	Result Date	Therapy Case	Therapy Reactor
Tested						Date Started	Date Completed
Read							
Result							

ALL SECTIONS BELOW MUST BE COMPLETED OR FORM WILL BE REJECTED.

Physical Exam

To be completed by examining physician

Height _____ Weight _____ Vision R20/_____Vision L20/ _____

Ears: (Otoscopic) _____ Glasses Yes/No Contacts Yes/No

Hearing: R ____ Hearing: L _____

Glands: Cervical _____

Thyroid: _____

Lungs: R _____
Lungs: L _____

Prone to Colds, Allergies, URL's Yes/No
Hx of middle ear infections? Yes/No
Any episodes of vertigo? Yes/No

Heart: Rate _____ BP: _____
Congenital defects _____

Abdomen _____
Skin _____
Teeth _____

Menstrual Condition: _____
Prone to dysmenorrheal _____
Prone to amenorrhea _____

Extremities: Hx of sprains, strains, dislocations, fx
_____

Hx of head injuries _____
Prone to headaches _____

Hx of knee injuries/problems _____
_____

Scoliosis Result _____
Can student participate in gym? Yes/No

Physician's Practice Stamp:

Physician's Signature _____
Date of visit _____