

ST. MARIA GORETTI SCHOOL
STUDENT ADMISSION HEALTH RECORD

Physician Report
2009-2010

Students Name _____ Male _____ Female _____ DOB _____

OBJECTIVE DATA

Height _____ Weight _____ B/P _____ Pulse _____

PHYSICAL EXAMINATION

Allergies _____ GU _____
Skin/Hair _____ Nutrition _____
Throat _____ GI _____
Nose _____ Orthopedic _____
Ears _____ Lymph _____
Eyes _____ ADD/ADHD _____
Heart _____ Scoliosis _____
Lungs _____ Teeth/Gums _____

Other illnesses or medical conditions _____

Surgeries _____

Should physical activity be restricted? _____ If YES specify degree _____

IMMUNIZATION HISTORY **MUST BE CURRENT TO ENTER SCHOOL**

Diphtheria
DPT Pertussis 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ **6.Td** _____
Tetanus M/D/Y M/D/Y M/D/Y M/D/Y M/D/Y M/D/Y

Oral Polio/IPV 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
M/D/Y M/D/Y M/D/Y M/D/Y M/D/Y

Hepatitis B 1. _____ 2. _____ 3. _____ 4. _____
M/D/Y M/D/Y M/D/Y M/D/Y

Measles
MMR Mumps 1. _____ 2. _____
Rubella M/D/Y M/D/Y

Varicella Vaccine 1. _____ 2. _____ **other** _____ **other** _____
OR M/D/Y M/D/Y M/D/Y M/D/Y

Active Chicken Pox 1. _____
M/D/Y

HIB 1. _____ 2. _____ 3. _____ 4. _____
M/D/Y M/D/Y M/D/Y M/D/Y

Date of Examination: (must be within 1 year of admission) _____
M/D/Y

Physician Name: _____

Address: _____

Phone: _____

Physician Signature: _____

ST. MARIA GORETTI SCHOOL
STUDENT ADMISSION HEALTH RECORD
Parent/Guardian Report
2009-2010

This side of this form needs to be filled out by a parent/guardian. The opposite side must be completed by your child's physician.
THE ENTIRE RECORD MUST BE COMPLETED AND RETURNED ON OR BEFORE BOOK DAY FOR SCHOOL ADMISSION

Students Name: _____ Age _____ Grade _____

Fathers Name: _____

Address: _____ Phone: _____

Mothers Name: _____

Address: _____ Phone: _____

MEDICAL HISTORY (Please check if your child has or has had any of the following)

- | | |
|---|--|
| <input type="checkbox"/> Allergies (seasonal/environmental) | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Meningitis/encephalitis |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Cancer (type _____) | <input type="checkbox"/> Nervous twitches/tics |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Congenital malformation | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Toothaches/dental surgeries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy/seizures | |
| <input type="checkbox"/> Eye or vision problems | Explain any of the above checked items _____ |
| <input type="checkbox"/> Frequent headaches/migraines | _____ |

ALLERGIES

Medication/Drugs _____

Food _____

Plants/Animals _____

Recommended treatment _____

MEDICATIONS

List all medications that are taken at home or at school (i.e. Concerta, Zyrtec, Albuterol, Flovent)

Name: _____ Dosage: _____ When taken: _____ Why taken: _____

Name: _____ Dosage: _____ When taken: _____ Why taken: _____

Name: _____ Dosage: _____ When taken: _____ Why taken: _____

DENTAL EXAMINATION

Date of last dental examination: _____

Dentist: _____

Follow up care needed: _____

Parent Signature: _____ Date: _____