

Saint Agnes Boys High School

Medical Form

This form must be completed by a medical doctor **after** June 16 and returned to Saint Agnes Boys HS before August 30. Students are not permitted to attend unless this form is on file at the school.

Student's Last Name _____ First Name _____ Date of Birth _____

Immunization History			
Type	Date	Date	Date
Chicken Pox			
DPT & Booster			
Hepatitis B			
Mantoux PPD Skin Test			
Measles			
Mumps			
Oral Trivalent (Polio)			
Rubella			

Orthopedic/Scoliosis
Structural
Posture
Feet
Scalp
Teeth
Throat

List any medications this student is taking:

Doctor's Recommendation for Physical Activity in School

- ___ Full physical activity
- ___ Modified physical activity
- ___ Specific physical activity contra-indication:

I certify that this student: (Please circle one)

is / is not physically qualified to participate in interscholastic and intramural sports. *This certification must be renewed each school year.*

Please **circle** any sports category that this student may **NOT** participate in for health reasons:

May **NOT** participate in contact sports, such as soccer, tackle football.

May **NOT** participate in limited contact sports, such as baseball, touch football, basketball, handball, volleyball

May **NOT** participate in strenuous, non-contact, such as cross-country track, track and field, tennis, swimming, weight training.

May **NOT** participate in non-strenuous, non-contact sports, such as golf or bowling.

Signature of Physician

Date of Exam _____

(Exam must take place after June 16 for upcoming school year)

Physician's Stamp, including address and telephone:

Please place a check to the left of any condition this student has had	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Orthopedic problem
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Epilepsy/convulsions	<input type="checkbox"/> Rubella
<input type="checkbox"/> Gastrointestinal problem	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Glasses/Contacts worn	<input type="checkbox"/> Sinus/Ear/Nose/Throat
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> TB or contact with TB
<input type="checkbox"/> Kidney/bladder infection	<input type="checkbox"/> Vision problem
<input type="checkbox"/> Measles	<input type="checkbox"/> Whooping Cough

Please explain any serious illness, injury or operation:

Please list all allergies:

Physical Examination.

Height _____ Weight _____ Blood Pressure _____

Specify all abnormal findings, whether handicapping or not:

Abdomen
Ears
Emotional
Eyes
Genito-Urinary
Glands
Hearing
Heart
Lungs
Nose
Nutrition