

CHRISTIAN BROTHERS ACADEMY

HEALTH OFFICE PHONE:

452-9809, EXT. 128

FAX: 452-9804

SCHOOL HEALTH EXAMINATION

Student Name: _____ Date of Birth: _____ Grade: _____ School yr _____
Address: _____

PHYSICAL EXAM

Height: _____ Weight: _____ BMI _____
BP _____ / _____ (sitting/standing/lying down, right arm /left arm)
Eyes: R _____ L _____ Visual acuity: L _____ R _____
Ears: (Otoscope) R _____ L _____
Audiogram: R _____ L _____
Lymph Nodes: _____
Thyroid: _____
Nose: _____
Tonsils: _____
Teeth: _____
Heart: _____
Lungs: _____
Hernia: _____
Genito-Urinary _____
Tanner: _____

State legislation mandates scoliosis screening for each child between the ages of 8 and 16 years

Screening negative Screening positive
Follow-up _____
Skin: _____
Nutrition: _____
Speech: _____
Other: _____

Please complete the above information for students who plan to participate in interscholastic sports. Thank-you.

Resting pulse: _____ Rate post exercise _____
Post 2 min. rest: _____
Urinalysis: _____
Protein: _____ Sugar: _____

Office stamp below please:

IMMUNIZATION RECORD

DtaP or specify _____ /_____/_____
_____ /_____/_____, _____ /_____/_____
_____ /_____/_____, _____ /_____/_____
Polio _____ /_____/_____, _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
HIB _____ /_____/_____, _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
MMR _____ /_____/_____, _____ /_____/_____
Hepatitis B _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
Varivax _____ /_____/_____, _____ /_____/_____ Varicella Illness _____ /_____/_____
Menactra _____ /_____/_____, Other _____ /_____/_____
Gardasil _____ /_____/_____, _____ /_____/_____, _____ /_____/_____
Or attach Immunization Record _____

HEALTH HISTORY

Allergies: _____
Asthma: _____
Chronic Conditions: _____
Physical Limitations: _____
Any restrictions to full participation in physical education?

For secondary students (grades 7-12): Please check if qualified for Interscholastic sports:

- Contact/Collision Limited Contact/Impact
- Strenuous Non-Contact Non-strenuous Non-contact

I HAVE COMPLETED THE ABOVE PHYSICAL AND FIND THAT THIS STUDENT IS QUALIFIED TO PARTICIPATE IN ALL THE CHECKED CATEGORIES OF COMPETITION DURING THE SCHOOL YEAR.

Signed: _____
Medical Examiner, Title

Date of Exam _____ /_____/_____

FOR SCHOOL USE ONLY: INTERVAL HISTORY COMPLETED BY SCHOOL NURSE.

Fall: _____ /_____/_____
Sport _____ Winter: _____ /_____/_____
Sport _____ Spring: _____ /_____/_____
Sport _____