ARCHBISHOP JOHN CARROLL HIGH SCHOOL
211 MATSON FORD ROAD
RADNOR PA 19087-4590

HEALTH OFFICE

**MEDICAL EXAMINATION to be completed by FAMILY PHYSICIAN**

Student No. __ __ __ __ __ __ __ __

Date of Birth

____________ Last Name ____________ First Name __ In. ___/___/___ Mon Day Year ______ Grade

____________ Address ____________ City ______ Zip Code ______ Telephone Number

**IMMUNIZATION STATUS:** Please complete information on back page.

**TUBERCULIN TEST DATE:** ____________ **RESULT:** ________

Students entering school for the first time in Pennsylvania must have a tuberculin test within six months prior to Admission, and Grade 9.

Medical History [Operations, Allergies, Serious Illnesses, Accidents, etc.]

REPORT OF EXAMINATION (Elaborate below on positive findings)

| | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|
| General Nutrition | | | Glands | | | Skeleton | | |
| Skin | | | Heart | | | Posture | | |
| Eyes | | | Lungs | | | Emotional Status | | |
| Ears | | | Abdomen | | | Hearing | | |
| Nose & Throat | | | Genitalia (male) | | | Scoliosis (Bending Position) | | |
| Teeth & Gingiva | | | Neuro Muscular System | | | Vision R 20/ L20/ | | +Lens |
| | | | Speech | | | Wears Corrective Lenses | Yes | No |

PULSE ______ BLOOD PRESSURE ______ HEIGHT ____ WEIGHT ____ BMI# ____/____%

Is this BMI in recommended range? YES ____ NO ____ Was counseling initiated? YES ____ NO ____

Does this student have asthma? YES ____ NO ____

Does this student use an inhaler? YES ____ NO ____ If so, how often is the inhaler used? ____________

Does this student carry and self-administer an inhaler? YES ____ NO ____

Does this student need a *backup* inhaler which can be kept in the school Health Office? YES ____ NO ____

Does this student take daily medication for asthma? YES ____ NO ____

Is this student under treatment for ANY medical condition? *YES ____ NO ____
Diagnosis: ____________

Is the student allergic to any medications, foods, bee stings, etc.? *YES ____ NO ____

Is the student taking ANY medications? *YES ____ NO ____

*Explain any YES responses.

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## IMMUNIZATION STATUS:

| VACCINE | DOSES (Enter month, day, and year each immunization was given) | | | | |
|---|---|---|---|---|---|
| Diphtheria and Tetanus (DTaP, DTP, Td or DT) | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Tetanus, Diphtheria and Acellular Pertussis (Tdap)* | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Polio (OPV or IPV) | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Hepatitis B | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Measles--Mumps--Rubella (MMR) | 1 / / | 2 / / | or Measles Serology: Date ______ Titer ______ | | |
| Varicella (Vaccine or Disease) | 1 / / | 2 / / | Rubella Serology: Date ______ Titer ______ | | |
| Meningoccal (MCV)* | 1 / / | 2 / / | Mumps disease diagnosed by physician: Date ______ | | |
| Other | 1 / / | 2 / / | | | |
| | *Age appropriate dose of MCV and Tdap are required for entry to 7th grade. | | | | |

Should this student have restrictions on school or physical education activities? *Yes ____ NO ____

Do you wish to make recommendations to coach, teachers, nurse? *YES ____ NO ____

*Explain any YES responses.

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The student may participate in the following athletic activities:

____All Interscholastic Athletic Activities
____Baseball
____Basketball
____Bowling
____Cheerleading
____Cross Country
____Field Hockey
____Football
____Golf
____Ice Hockey
____Indoor Track
____Lacrosse
____Outdoor Track
____Soccer
____Softball
____Swimming
____Tennis
____Volleyball
____Wrestling

______________________________ Signature of Examining Physician

______________ Date

______________________________ Address

______________ Telephone Number