

THE SETON KEOUGH HIGH SCHOOL

Part I - Student Information

STUDENT'S FULL NAME _____ GRADE _____

Date of Birth _____ Home Telephone _____

Home Address _____

Parent/Guardian's Full Name _____

Mother's Cell Telephone _____ Mother's Work Telephone _____

Father's Cell Telephone _____ Father's Work Telephone _____

Part II - Physical Exam - To be completed by Primary Physician or Nurse Practitioner

Date of Exam _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

Is there any reason for concern in any of the areas listed below? Indicate by placing a \checkmark in the appropriate space.

Health Area	Evidence for Concern ?		Health Area	Evidence for Concern?	
	Yes	No		Yes	No
Cardiovascular System			Musculoskeletal System		
Respiratory System			Integumentary System		
Renal System			Hearing or Speech		
Endocrine System			Vision - Near Sighted		
Neurological System			Vision - Far Sighted		

Please explain any checked (\checkmark) item, including recommendations for referral and treatment and any restriction on physical activity in school.

Does this child have a health condition which may require EMERGENCY ACTION while she is at school? (e.g. seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem?) no yes

If yes, please describe:

Clearance

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

Not cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Physician/Nurse Practitioner Signature _____

Physician/Nurse Practitioner Name (print) _____

STUDENT'S FULL NAME _____ GRADE _____

Part III - Student Health History *To be completed by parent/guardian*

Has your daughter HAD or does she HAVE any of the following? Please explain "Yes" answers in the space provided or at the end of the table. **If medication is needed for any condition during school hours, please send in the medication to the school nurse along with a signed Physician's Authorization Form.**

Birth Defects	Yes	No		Impaired Vision (glasses, contacts)	Yes	No	
Hospitalizations/Surgeries	Yes	No		Impaired Hearing (aids, etc.)	Yes	No	
Chronic Illnesses or Conditions	Yes	No		Behavior Issues (ADD, ADHD, etc.)	Yes	No	
Allergies (medicine, environmental, food, insects, seasonal, etc.)	Yes	No		Recent Emotional/Life Stress (divorce, death, relocations, etc.)	Yes	No	
Sickle Cell Anemia	Yes	No		Depression/Anxiety	Yes	No	
Anemia	Yes	No		Migraines/Headaches	Yes	No	
Diabetes	Yes	No		Seizure Disorder/ Epilepsy	Yes	No	
Take medication regularly @ home and/or @ school. TYPE/ DOSE	Yes	No		Skin Conditions (acne, rash, hives, sores, warts, etc.)	Yes	No	
Mononucleosis	Yes	No		Scoliosis	Yes	No	
Asthma	Yes	No		Dental (braces, caps, partials, etc.)	Yes	No	
Under Physician's Care	Yes	No		Menstrual Problems	Yes	No	
Pertaining to Heart: Shortness of breath..... Tires easily..... Heart racing/skipping..... High or low blood pressure..... High cholesterol..... Family history of heart problems or sudden death < 50 yrs old?.... Restricted activity advised by a doctor due to heart problems?.....	Yes	No		Pertaining to Exercise: (during or after) Passed out..... Rash..... Dizziness.... Chest pain.... Shortness of breath.... Illness from heat... Cough, wheezing, asthma... Restricted physical activity advised by a doctor?...	Yes	No	
Broken Bones	Yes	No		Shoulder Injury	Yes	No	
Joint Dislocation	Yes	No		Back Injury	Yes	No	
Foot Problems	Yes	No		Knee Injury	Yes	No	
Neck Injury	Yes	No		Elbow Injury	Yes	No	
Head Injury or Concussion	Yes	No		Hand Injury	Yes	No	
Loss of Consciousness or Memory Loss	Yes	No		Sprains/Tears	Yes	No	
Skull Fractures	Yes	No		Convulsion/Seizures	Yes	No	

EXTRA SPACE FOR COMMENTS

Is there any reason this student should not take part in any sport? _____

Parent/Guardian Signature _____ Date _____