

SAINT EDMOND'S ACADEMY PHYSICAL EXAMINATION FORM

2120 Veale Rd. Wilmington, DE 19810 • P 302-475-5370 F 302-475-2256

For ALL NEW STUDENTS and RETURNING STUDENTS GRADES 4 AND 7

SECTION A - To be filled in by parent before physical examination

NAME _____ SEX_M_ BIRTHDATE _____ GR _____

ADDRESS _____

ILLNESS: Check and give approximate date your child had any of the following:

HANDICAPS: Check if your child has any problems with any of the following and give additional comments

ALLERGIES:							
ADD/ADHD		German Measles		Mumps		Tuberculosis	
Asthma		Hearing Difficulty		Physical Handicaps		Vision Difficulty	
Chicken Pox		Heart Trouble		Pneumonia			
Constipation		Lyme Disease		Rheumatic Fever		Other:	
Diabetes		Migraine Headaches		Scarlet Fever			
Epilepsy/Seizures		Measles		Speech Difficulty			
Frequent Ear Infections		Mononucleosis		Strep Throat			

ADDITIONAL INFORMATION ABOUT YOUR CHILD (Include accidents, operations, etc. with dates: _____)

SECTION B - To be completed by examining physician

(Please indicate condition by code and give details under positive findings)

Height _____

B.P. _____ P. _____

Code _____ No Defect

Weight _____

Urinalysis

1- defect, correction or care not necessary

S.G. _____ Alb. _____ Sugar _____

2- defect, see remarks below

Nutrition		Ears/Nose Throat		Neck		Hernia	
Scalp-Skin		Hearing R		Glands		Extremities	
Yes:		Hearing L		Heart		Nervous System	
Distant R 20/	Corr. to 20/	Teeth-temp.		Lungs		Posture	
Vision L 20/	Corr. to 20/	Teeth-perm.		Abdomen		Other	

POSITIVE FINDINGS (Include any additional pertinent history): _____

RECOMMENDATIONS (List any limitation of activity that child should observe): _____

DTP/DT 1	DTP/DT2	DTP/DT 3	DTP/DT 4	DTP/DT 5
OPV/IPV1	OPV/IPV2	OPV/IPV3	OPV/IPV4	OPV/IPV5
MMR1	MMR2	HEP B1	HEP B2	HEP B3
HIB1	HIB2	HIB3	HIB4	Other
Td1	Varicella 1*	Varicella 2*	Lead Level**	Other
	*all new students	*all new students	**JK & K Only	

Immunizations given at this visit _____

MANTOUX Tuberculin Skin Test Date (required for new students) _____

Result _____

Examiner's Signature _____ M.D. P.N.P. Date _____

Printed Name _____ Telephone _____

Address _____

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Student History: Name _____ Date of Birth _____

<i>Explain YES answers below if your child has ever had or experienced</i>	YES	NO
Surgery or hospitalization		
Fracture, sprain, joint swelling or pain		
Head injury or seizures		
Headaches		
Dizziness, fainting or unconsciousness		
Fainted from heat, had heat or muscle cramps		
Hay fever, seasonal allergies		
Asthma, cough or difficulty breathing after exercise		
Heart murmur, skipped beats or racing heart rate		
High blood pressure		
Any family member with sudden death before age 50		
Stomach or intestinal problems		
Voiding difficulty or lack of control		
Skin problems such as rash, itch, acne, etc.		
Vision problems such as diabetes, recurrent infections, etc.		
Any speech or hearing difficulties, therapy or hearing aids		
Problems such as diabetes, recurrent infections, etc.		
Allergies to bee stings, insect bites, medications or food		
Taking any medications or pills		
Dental braces, false or loose teeth, mouth guards		
Nosebleeds or other bleeding problem		
Any restriction in physical education/gym class/sports		
Medical problem or injury since last exam		

Explain YES answers: _____

Parent's Consent for Intra/Interscholastic Sports

_____ has my permission to participate in the following intra/interscholastic sports:

	Baseball		Basketball		Kickball
	Hockey		Physical Education		Soccer
	Cross Country		Track		Volleyball
	Wrestling		Lacrosse		

The permission extends to all activities, whether conducted on or off the school premises, and waives any claim for injury or damage incurred by said participant while taking part in the referred to activities. The parent whose signature appears below will be responsible for any athletic equipment and material loaned to the students, and will insure its prompt return at the close of the school year or sooner, if required.

Parent Signature

Date

Health Care Provider's Consent for Intra/Interscholastic Sports

On the basis of history and examination, this student will be able to participate in competitive sports for the year _____.

With any limitations: _____

Examiner's Signature/Certified N.P. or P.A.

Examiner's Signature/ M.D. or D.O.

Date

Please Complete Reverse Side