



**ST. PETER CLAVER HIGH SCHOOL
MEDICAL FORM**

Today's Date: _____

Student's Legal Last Name	Legal First Name	Legal Middle Name	Date of Birth
---------------------------	------------------	-------------------	---------------

PART 1: HEALTH HISTORY

(To be completed and signed by parent/guardian and health care provider.)

List all allergies (food, drug, insect, other). Anaphylaxis? Comments			MEDICATIONS (list all taken on a regular basis) Comments		
Asthma?	Y N		TB?	Y N	
Birth Defects?	Y N		Hospitalized? When? Why?	Y N	
Blood Disorder?	Y N		Surgeries? When? Why?	Y N	
Diabetes?	Y N		Please share any other concerns or pertinent information:		
Seizures?	Y N				
Heart/Breathing Problems	Y N				
Heart Murmur / HBP?	Y N				
Dizziness / Chest Pain?	Y N				
Eye/Vision Problems?	Y N				
Ear/Hearing Problems?	Y N				
Bone/Joint Problems?	Y N				
Dental Problems?	Y N				

PART 2: PHYSICAL EXAMINATION

(To be completed by a competent medical authority)

Physical Examination Requirements	Height _____	Weight _____	BP: Systolic _____
	Diastolic _____		
At Risk of Diabetes? Y N	If yes, please explain:		
System Review	Normal?	Comments	Normal?
Skin	Y N		Endocrine Y N
Ears/Hearing	Y N		Gastrointestinal Y N
Eyes/Vision	Y N		Genito-Urinary Y N
Throat	Y N		Neurological Y N
Mouth/Dental	Y N		Musculoskeletal Y N
Cardiovascular/HTN	Y N		Spinal examination Y N
Respiratory	Y N		Nutritional status Y N
			Mental health Y N
Needs/Modifications in school setting?			
Approved for physical education and manual labour? YES or NO. If NO please explain.....			

On the basis of the examination on this day, I approve this child's participation in all the activities of a boarding secondary school YES NO MODIFIED If "No" or "Modified" is ticked please explain:.....

Name of Medical Specialist performing the examination: _____
Signature: _____ Title: _____ Date: _____ Phone No: _____

NB: Please attach any document of any problem detected and bring also medicine prescribed or given.
Thank you.