Archbishop Molloy High School
83-53 Manton Street
Briarwood, New York 11435

Medical Report
(TO BE COMPLETED BY PHYSICIAN)

Student's Last Name_____**First Name**_____**Middle Initial**____**DOB**_____

VACCINE TYPE	DATES OF VACCINATION				
DPT or Dt or Td					
Tdap					
Polio TOPV					
IVP (Salk)					
MMR					
HIB					
HepatitisB					
Varicella					
Meningococcal			Other:		

History (Please review parent's history on reverse side and make any pertinent additions)

Allergies_____ Medication Allergies_____

Asthma History Yes_____ No_____ Age of Onset_____ Last Episode (Year) _____

Epi-Pen Prescribed Yes_____ No_____ Medication: Inhaler Type_____

PHYSICAL EXAMINATION: (List all abnormal findings whether handicapping or not)

Weight_____Height_____BMI_____ (____%ILE) _____Blood Pressure_____Pulse_____

Scoliosis check_____

SCREENING TESTS RESULTS - WITHIN THE YEAR

VISION

NEAR: With Glasses R_____ L_____ FAR: With Glasses R_____ L_____

Without Glasses R_____ L_____ Without Glasses R_____ L_____

HEARING (Audiometric Screening

Sweep -- __Pass __FAIL Threshold -- __Pass __Fail

HEMOGLOBIN_____ HEMATOCRIT_____

PPD (Mantoux) **Last dated results**	IF POS. GIVE X-RAY FINDINGS DATE	On INH DATE
__Negative __Positive		
mm Induration_____		
Date:_____		

URINALYSIS:

Sugar_____ Protein_____ Other_____

FOLLOW-UP (Referrals for Follow-up appointments made):

RECOMMENDATIONS FOR PHYSICAL ACTIVITY IN SCHOOL & TRYOUTS FOR SPORTS:

__ **Free from contagions & physically qualified for all physical education, interscholastic sports, work & school activities OR only as checked:**

__ **Limited contact:** cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball

__**Non-contact:** badminton, bowl, golf, table tennis, archery, weight train, crew, dance, track, run, walk, rope jump

__**Restrictions & or suspected disability:** _____

SIGNATURE OF PHYSICIAN DATE OF EXAM

PRINT OR TYPE NAME OF PHYSICIAN **PLEASE STAMP**

ADDRESS BOROUGH ZIP TELEPHONE NO.

CONTINUED ON OPPOSITE SIDE - PLEASE TURN OVER

THIS FORM MUST BE RETURNED TO THE SCHOOL NURSE BEFORE THE FIRST DAY OF SCHOOL!

MEDICAL HISTORY AND REPORT FORM

(TO BE COMPLETED BY THE PARENT/GUARDIAN)

LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH** **__MALE** **__FEMALE**

NAME OF PARENT OR GUARDIAN (LAST) **FIRST** **RELATIONSHIP TO CHILD**

ADDRESS **BOROUGH** **ZIP CODE** **APT NO. OR FLOOR** **TELEPHONE** **Home:** **Office:**

GRADE/CLASS _____ **LANGUAGE SPOKEN AT HOME**_____

Family Medical/Hospital Insurance Company_____ **Policy or Group #**_____

Please circle **S** to indicate **student** or **F** to indicate a **family history** of any conditions, past or present. Please provide details below (attach any pertinent information)

Allergies/Hay Fevers/ Food Allergies	S	F	Hearing	S	F
Insect/Sting Allergy	S	F	Heart Murmur/Rheumatic Fever/Heart Disease	S	F
OD/ADHD/ADD	S	F	Hepatitis	S	F
Anemia/Sickle Cell	S	F	Hernia	S	F
Arthritis	S	F	Lead	S	F
Asthma (give details below)	S	F	Lung Disease/TB	S	F
Back/Neck Injury or conditions	S	F	Measles	S	F
Bladder Kidney Problems	S	F	Medication Reaction	S	F
Blood Clotting Disorder	S	F	Mononucleosis	S	F
Cancer/Leukemia	S	F	Orthopedic Bones/Scoliosis	S	F
Chickenpox	S	F	Psychological/Psychiatric	S	F
Seizures/Epilepsy/Convulsions	S	F	Surgery	S	F
Diabetes	S	F	Speech	S	F
HeadInjury/Concussion	S	F	Vision	S	F
Headaches	S	F	History of Eating Disorders	S	F

Please give details for all CIRCLED: _____

_____

Is the student under any medical care or treatment? Yes_____ **No**_____ **Explain**_____

_____

Does the student take any medications (prescribed &/or OTC)? Yes_____ **No**_____ **Explain**_____

_____

Specifically, during or after exercise has the student experienced any of the following? CIRCLE all that apply.

Fainting/Passing out Heat Stroke Severe Lightheadedness/Dizziness Coughing/Wheezing Extreme Shortness of Breath
Excessive Bruising Chest Pain Numbness/Tingling in: _____

Was a medical evaluation done? Yes No Result of exam_____

Has the student ever been denied athletic participation for medical reasons? Yes No Explain_____

THIS SECTION MUST BE SIGNED TO COMPLETE MEDICAL FORM:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed school and Esopus camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the school and camp to order X-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of school.

Signature of parent or guardian X_____

I also understand and agree to abide with the restrictions placed on my school activities.

Signature of minor X_____

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Entry into Archbishop Molloy High School is prohibited by law unless this certificate is on file.