ST. JOHN'S PREPARATORY SCHOOL

School Health New Admission Examination Form

Grade

Student ID #

Social Security #

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student: Last Name	First Name	Middle	SEX	BIRTHDAY	Place of Birth:
			⬡ Male ⬡ Female	M D Y / /	⬡ USA, State: ⬡ Country:

Parent/Guardian: Last Name	First Name	Ethnicity:
		Hispanic, Black, Am. In., White, Asian, Other:

STUDENT ADDRESS:

Apt/Fl

ZIP

Telephone No.

Work ( )

Home ( )

School District | School Name

⬡ Public JHS/IS ⬡ Public HS ⬡ Non-Public

TO BE COMPLETED BY THE HEALTH PROVIDER

Does the student have a past or present medical history of the following:

			REASON	DATE	PLACE
Allergies	Cancer	Hospitalizations			
Asthma	Orthopedic Problems	Surgery - What Kind?			
Congenital Heart Disease	Vision Problems	Serious Illness			
Convulsions	Hearing Problems	Serious Accidents			
Diabetes	Speech Problems	Other Problems/Limitations			

CHILD HISTORY

FAMILY HISTORY

PHYSICAL EXAMINATION: Height Weight Blood Pressure /

General Appearance (Nutritional Status)

NL	AB		NL	AB		NL	AB		NL	AB	
⬡	⬡	HEENT	⬡	⬡	Lungs	⬡	⬡	Extremities	⬡	⬡	Psych/Social
⬡	⬡	Dental Status	⬡	⬡	Cardiovascular	⬡	⬡	Back	⬡	⬡	Language
⬡	⬡	Neck	⬡	⬡	Abdomen	⬡	⬡	Skin	⬡	⬡	Behavioral
⬡	⬡	Lymph	⬡	⬡	GenitoUrinary	⬡	⬡	Neuro	⬡	⬡	Gross Motor
									⬡	⬡	Fine Motor

Describe Abnormalities:

SCREENING TESTS:	DATE	RESULTS	
Hematocrit/Hemoglobin	__/__/__	________	MM
HGB Electrophoresis	__/__/__	________	MM
Other Tests	__/__/__	________	

HEARING:	DATE	RESULTS	
Audio/Sweep	__/__/__	P	F
Threshold	__/__/__	P	F

VISION: DATE: __/__/__		
FAR	P	F
NEAR	P	F
FUSION	P	F
COLOR	P	F

TB: For Intermediate/Middle School/Junior High School and High School **FIRST TIME ENTRANTS**

Mantoux	DATE	RESULTS	
(PPD)Implanted	__/__/__	⬡ Negative ________	MM
Read	__/__/__	⬡ Positive ________	MM

	Chest X-ray	BCG	On INH
DATE	__/__/__	__/__/__	__/__/__
RESULTS	⬡ Normal ⬡ Abnormal ⬡ Not Indicated	⬡ Yes ⬡ No	⬡ Yes ⬡ No

LEAD:

	DATE	RESULTS	If at risk,	DATE	RESULTS
Do Risk Assessment	__/__/__	⬡ No Risk ⬡ At Risk	do venous screening	__/__/__	________

IMMUNIZATION - DATES

DPT/DTaP or Dt or Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
POLIO: TOPV (Sabin)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
IPV (Salk)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hepatitis B	__/__/__	__/__/__	__/__/__			
HIB	__/__/__	__/__/__				

Measles	__/__/__	__/__/__
Mumps	__/__/__	__/__/__
Rubella	__/__/__	__/__/__
MMR	__/__/__	__/__/__
VZV	__/__/__	__/__/__

RECOMMENDATIONS FOR PHYSICAL ACTIVITY IN SCHOOL, ALSO IN EXTRACURRICULAR ACTIVITIES INCLUDING INTRAMURALS, INTERSCHOLASTIC COMPETITION AND WORKING PAPERS:

____ Full Physical activities including physical education, aerobics and contact sports.

____ **Student is also approved for working papers.**

____ Modified physical activity (Specify)

____ Specific physical activity contraindicated?

Special recommendations or modifications in pupil's program

Date of Examination:

MUST BE MECHANICALLY STAMPED

Physician's Name:

Address:

Name of Facility:

Telephone:

Physician's Signature