

PLEASE BE ADVISED THAT ALL STUDENTS ARE REQUIRED TO SUBMIT THIS FORM. DUE NO LATER THAN JULY 31st FOR THE COMING SCHOOL YEAR

Please note: It is imperative that our Health Office be apprised of your son's medical history. Since medical conditions change from year to year we ask your cooperation in filling out this form each year. Every student must have his Official Health and Immunization records on file in the Health Office throughout the student's tenure at Saint John's. Every student entering Saint John's (as a freshman or a transfer student) must also submit a copy of a current physical (please see reverse side of this form). In addition, every student who wishes to participate in interscholastic sports is required to have a physical examination annually, and must submit proof of this examination to the Health office each year.

PART A TO BE COMPLETED BY PARENT OR GUARDIAN

Student's Name: _____ (Print clearly)

- 1. Has your son had to seek medical attention in the past two years? If yes, for what reason?
2. Does your son have/had disease(s) that affects the function of the eye, ear, testicle, kidney or lung? If yes, please explain.
3. Please list any fractures, sprains, bone dislocations or operations: (Please include date and age.)
4. Does your son wear glasses or contact lenses?
5. Does your son take any medications daily? If yes, please list medication(s) and the purpose for the medication.

Does he take this medication during the school day? _____

6. Has your son ever had any of the following? Please circle Y for yes and N for no.
Asthma/allergies y n Mononucleosis y n
Inhaler for asthma y n Does student carry inhaler y n
Fainting or convulsions y n Pneumonia y n
Heart murmur/condition y n Hepatitis y n
Rheumatic fever y n Bronchitis y n
Kidney Disease or injury y n Head injury y n
Heat stroke/exhaustion y n Concussion y n
Arthritis/joint problems y n Tumors y n
Seizures y n Bridges or false teeth y n
Diabetes y n Insulin dependent y n
Will your son be testing blood sugar before/during/after school? ___before ___during ___after
Will your son be carrying/self administering insulin during the school day? y n
Please list any precautions we should understand regarding your son's diabetes: _____

7. Does your son take medication for Bee Stings/Insect Bites? Y N If yes, what medication?
If your son needs Epi-pen, he is required to either have parental permission to carry the Epi-pen or if the Epi-pen is to be kept in the Health Office it must be submitted before the first day of school, clearly marked with the student's name, year of graduation, expiration date, including complete instructions regarding the circumstances under which the student should self administer the Epi-pen. No student will be allowed to attend school unless written permission is on file to carry the Epi-pen or and Epi-pen is in the office.

PLEASE NOTE: The school nurse will dispense over-the-counter meds (Tylenol, Ibuprofen, Tums etc.) with parental consent.

Signature of Consent: _____

If there are any other health issues (i.e. allergy to medication) that the school should be aware of please explain briefly: _____

I HEREBY GIVE MY PERMISSION FOR MY SON TO PARTICIPATE IN ALL SCHOOL ACTIVITIES.

(Signature of parent/guardian) (Date)

Please provide us an alternate name and phone number in case of an emergency:

Name: _____ Phone: _____

PART B TO BE COMPLETED BY EXAMINING PHYSICIAN

Student's Name: _____ Date of Birth _____

(Print clearly)
Height _____ Weight _____ Blood Pressure _____

Eyes _____ R20/ _____ L20/ _____ Ears/Hearing: R _____ L _____

Significant past illness(es) and or injury(ies):

Cardiovascular _____

Musculoskeletal _____

Respiratory _____

Urinalysis _____

In order to update our school health record please list the immunizations:

Polio _____ Most recent Tetanus/TD _____

#1MMR _____ #2MMR _____

Hep B Series _____ Varicella or Chickenpox _____ Tine Test (TB) _____

Do you have any restrictions or physical limitations for this student? Y N If yes, please explain: _____

Date of examination: _____

Please print name of physician clearly _____

Physician's signature _____ (date)

THIS STUDENT MAY PARTICIPATE IN ALL SCHOOL ACTIVITIES WITH NO LIMITATIONS

This student has some restrictions / please explain:

Please return this completed form to the School Nurse, St. John's High School, 378 Main St., Shrewsbury, MA 01545