ST. EDWARD HIGH SCHOOL — HEALTH RECORD

Class (circle one)
9 10 11 12 Year of Graduation_____

Student's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ School Last Attended _____

Father's Name _____ Mothers' Name _____

Legal Guardian _____ Insurance Information_____

To be completed by physician

Height _____ Weight _____
Body Mass Index _____ Percentile _____
B/P _____
Hearing (Right) _____
Hearing (Left) _____
Teeth _____
Vision (Right) _____
Vision (Left) _____
Posture _____
Nutrition _____
Nutrition _____
Skin _____
Nasopharynx _____
Tonsils _____
Thyroid _____
Cardiovascular _____
Respiratory _____
Genitalia _____
Musculoskeletal _____
Neurological _____
Abnormal findings and recommendations:
_____
_____
_____

Medication being taken (include use of inhaler):
_____
_____
_____
_____

Allergies:_____
_____
_____
_____

Any reason why student cannot take part in supervised athletic activities: if so, why?
_____
_____
_____
_____
_____
_____

Is there anything that teachers need to know in order to understand this student better?
_____
_____
_____
_____
_____

Physician's Signature _____ Date of Exam_____
(must be completed **after June 1** and **due by August 1**)

Physician's Phone Number _____

If there are any questions regarding the information on this form, please contact St. Edward Health Clinic between 8:15 a.m. and 3:00 p.m. at 216-221-3776 Ext. 227	**Complete Reverse Side Required Immunization Information**

ST. EDWARD HIGH SCHOOL IMMUNIZATION RECORD

Ohio's Compulsory Immunization Law requires that all students must be protected against seven preventable diseases. Failure to provide verification of immunization against these diseases will result in **EXCLUSION FROM SCHOOL.**

Student's Name: _____ Date of Birth: _____

Please complete the following – All information is required

DTP/DT/Td Series - Five required

1. _____
month-day-year
2. _____
month-day-year
3. _____
month-day-year
4. _____
month-day-year
5. Tdap _____
month-day-year

COMBINED MMR
Measles, Mumps & Rubella

Two required: 1st dose on or after 1st birthday and 2nd dose before entering Junior High.

#1 _____(month-day-year)

#2 _____(month-day-year)

Mumps: Parent diagnosis is unacceptable; physician diagnosis or parent objections must be in writing and attached to this form.

Rubella: The only acceptable form of diagnosis is by laboratory testing. Physician or parent objections must be in writing and attached to this form.

POLIO - Three required

1. _____
month-day-year
2. _____
month-day-year
3. _____
month-day-year

4th dose must be given if 3rd dose was given before 4th birthday _____
month-day-year

VARICELLA VACCINE
(Chicken Pox)

_____
month-day-year

One dose of vaccine must be administered on or after first birthday

HEPATITIS B - Three required

1. _____
(month-day-year)
2. _____
(month-day-year) 28 days after first dose
3. _____
(month-day-year) 16 weeks after 1st dose or 8 weeks after 2nd dose

The last dose in the series (3rd or 4th dose) must not be administered before age 24 weeks.

Other Immunizations

_____

_____

Diseases:	Date
____Chicken Pox	_____
____Mumps	_____
____Measles (Rubeola)	_____
____Measles (Rubella)	_____
____Other	_____

Revised 4/15

_____
Parent or Physician Signature

Date: _____