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_____ Mother's 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_____
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 1st)

Physician's Phone Number _____

If there are any questions regrading 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

REV 02/11

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

Four required

1. _____ (month-day-year)
2. _____ (month-day-year)
3. _____ (month-day-year)
4. _____ (month-day-year)
5. Optional _____ (month-day-year)

POLIO

Three required

1. _____ (month-day-year)
2. _____ (month-day-year)
3. _____ (month-day-year)
4. Optional _____ (month-day-year) Optional

HEPATITIS B

Three required

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

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.

Other Immunizations

_____

_____

_____

Diseases	Date
☐ Chicken Pox	_____
☐ Mumps	_____
☐ Measles (Rubeola)	_____
☐ Measles (Rubella)	_____
☐ Other	_____

_____

Parent or Physician Signature

_____

Date

REV 02/11