

## MERCY HIGH SCHOOL/SAN FRANCISCO SCHOOL HEALTH FORM

Student's Last Name	Student's First Name	Age	Birthdate	Previous School Attended
Address	City	Zip	Home Telephone (include area code)	
Parent/Guardian Signature		Date		

**TO BE COMPLETED BY PHYSICIAN:**

This student has been under my care since: \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**DATE HEALTH EXAMINATION AND SCREENING COMPLETED:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Telephone (inc area code please):** \_\_\_\_\_

Please check [ ] if normal; if no, or other, please comment below:

Skin [ ]	Musculature [ ]	Posture & Body Alignment [ ]	Gait and Extremities [ ]	Ears [ ]
Ears [ ]	Eyes [ ]	Lungs [ ]	Throat (tonsils etc) [ ]	
Teeth [ ]	Abdomen [ ]	External Genitalia [ ]		

Refer to dentist \_\_\_\_\_

**Immunization Record (Please give the family a completed/updated yellow California Immunization Record)**

Vaccine	Month/Day/Year Each Dose Was Given				
	1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	4 <sup>th</sup> dose	5 <sup>th</sup> dose
Polio					
DPT					
Td/DT					
Hep B					
MMR					

Tuberculin Skin Test. Note: TB test required for school admission  
 Date: \_\_\_\_\_ Type: \_\_\_\_\_ Induration: \_\_\_\_\_mm  
 Impression: Negative: \_\_\_\_\_ Positive: \_\_\_\_\_

Chest X-ray required if skin test is positive  
 Date: \_\_\_\_\_ Impression: Negative: \_\_\_\_\_ Positive: \_\_\_\_\_

Regular medication taken for chronic condition (please specify) : \_\_\_\_\_

Is there any condition which limits participation in (if yes, please specify): \_\_\_\_\_ physical education : yes\_\_\_ no \_\_\_ competitive athletics : yes\_\_\_ no \_\_\_

**Health Examination revealed NO condition relevant to the school program, including classroom activities, physical education or competitive athletics**

**SIGNATURE OF PHYSICIAN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_