ADMISSIONS MEDICAL FORM

BISHOP LOUGHLIN MEMORIAL HIGH SCHOOL
357 CLERMONT AVENUE
BROOKLYN, NY 11238

RETURN BEFORE START OF SCHOOL!

STUDENT LAST NAME | STUDENT FIRST NAME | STUDENT MIDDLE INITIAL | ☐ MALE ☐ FEMALE | DATE OF BIRTH (MM-DD-YYYY)

STUDENT STREET | APT # | STUDENT CITY | STATE | ZIP CODE

PARENT NAME | RELATIONSHIP TO STUDENT | HOME PHONE | CELL PHONE

TO BE COMPLETED BY HEALTH CARE PROVIDER

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

EXPLAIN REASON/DATE

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

CHILD's HISTORY:

PHYSICAL EXAMINATION

NL	AB		NL	AB		NL	AB	
☐	☐	Abdomen	☐	☐	Fine Motor	☐	☐	Lungs
☐	☐	Back	☐	☐	Genitourinary	☐	☐	Lymph
☐	☐	Behavioral	☐	☐	Gross Motor	☐	☐	Neck
☐	☐	Cardiovascular	☐	☐	Hearing Problem	☐	☐	Neurological
☐	☐	Dental Status	☐	☐	HEENT	☐	☐	Psych/Social
☐	☐	Extremities	☐	☐	Language	☐	☐	Skin/Spine

Height: _____ Weight: _____ Blood Pressure: _____/_____
Body Mass Index: _____ BMI Percentile: _____

Any form of treatment now? _____
Any medications? _____
Specify: _____

VISION DATE: ____/____/____

Vision Uncorrected: R _____ L _____
Vision Corrected: R _____ L _____

TB: MANTOUX	DATE	RESULT	CHEST X-RAY
PPD Implanted	___/___/___	Negative _____	Date ___/___/___
Read	___/___/___	Positive _____	Result _____

IMMUNIZATIONS & DATES

HEP B: ___/___/___	___/___/___	___/___/___	___/___/___	MMR:	___/___/___	___/___/___	___/___/___
ROTAVIRUS:	___/___/___	___/___/___	___/___/___	VARICELLA:	___/___/___	___/___/___	___/___/___
DTP/DTaP/DT:	___/___/___	___/___/___	___/___/___	TD:	___/___/___	___/___/___	___/___/___
	___/___/___	___/___/___	___/___/___	TDAP:	___/___/___		
HIB: ___/___/___	___/___/___	___/___/___	___/___/___	HEP A:	___/___/___	___/___/___	
PCV: ___/___/___	___/___/___	___/___/___	___/___/___	MENINGOCOCCAL:	___/___/___	___/___/___	
POLIO: ___/___/___	___/___/___	___/___/___	___/___/___	HPV:	___/___/___	___/___/___	___/___/___
INFLUENZA:	___/___/___	___/___/___	___/___/___	OTHER, Specify: _____		___/___/___	

RECOMMENDATIONS For physical activity in school, extracurricular activities including intramurals, interscholastic competition and working papers.

___ Full Physical activities including physical education and competitive sports.
___ Student is also approved for working papers.
___ Modified physical activity (Specify) _____
___ Specific physical activity contraindicated? _____

MUST BE MECHANICALLY STAMPED

Physician's Name:
Name of Facility:
Address:
Phone #:

Physician Signature: _____
Date of Examination: ___/___/___