

**Greenwich Academy
Health Center Medical Form**



STUDENT'S NAME _____ **DOB** _____

Parent/Guardian _____ **Parent/Guardian** _____

Height _____ Weight _____ BMI _____ BP _____ Pulse _____

Vision: R _____ L _____ (with/without glasses) Contacts _____

Hearing: R _____ L _____ Scoliosis Screening _____

PHYSICAL EXAM: WNL _____

If any abnormal findings please describe _____

ALLERGIES: _____

History of a concussion. If yes, please give date(s): _____

Current medical problems (i.e. Asthma) _____

Significant past illnesses _____

IMMUNIZATIONS: Please list all dates

DPT,DT _____ TETANUS _____

POLIO _____ MEASLES _____

HIB _____ MUMPS _____

MMR _____ RUBELLA _____

PPD _____ CHICKENPOX – DISEASE _____ VARICELLA 1) _____

HEPATITIS B 1) _____ 2) _____ 3) _____ 2) _____

OTHER _____ HEPATITIS A 1) _____

MCV4 _____ Flu Vaccine _____ 2) _____

Activity full _____ Activity limited (explain) _____

I HAVE EXAMINED THIS STUDENT AND HAVE FOUND HER PHYSICALLY FIT TO PARTICIPATE IN PHYSICAL EDUCATION/SPORTS.

PHYSICIAN'S SIGNATURE _____ **DATE** _____

(Physician's Stamp)