

**OUR LADY ACADEMY-2011-2012
HEALTH RECORD/DOCTOR'S EXAMINATION**

This document is kept by the OLA Athletic Department. Its purpose is to insure that a student is physically fit to participate in athletics/activities sponsored by Our Lady Academy and/or St Stanislaus, and to record information which may be helpful to an attending physician in the event of an emergency.

Student's Full Name _____
Last
First
Middle

Part 1 (to be completed by Parents) Grade _____

Please answer Yes or No. Give date. Has student ever had or does she have.

YES	NO	DATE	YES	NO	DATE
Scarlet Fever _____			Ear/Throat Trouble _____		
Diphtheria _____			Asthma, Hay fever _____		
Rheumatic Fever _____			Tuberculosis _____		
Fainting, Epilepsy _____			Rupture, Hernia _____		
Convulsions _____			Appendicitis _____		
Mumps _____			Diabetes _____		
Eye Trouble _____			Nervous Disorders _____		
Heart Murmurs _____			Excess Bleeding _____		
Liver Disorders _____			Chicken Pox _____		
Bone injury _____			Surgery _____		
Accidents _____			Measles _____		
Allergies/Treatment _____			Other _____		

Student has had the following immunizations:

Tetanus Toxoid _____ Date _____ Polio _____ Date _____

Student has had unusual reaction: Tetanus antitoxin _____ Penicillin _____

Mycin _____ Sulfa _____ Other _____
(e.g. Codeine, iodine)

Using special medicines _____

X _____
Parent's Signature
Date (Good until August 1, 2012)

Part 2 (to be completed by Physician)

Height: ___ ft ___ inches Weight: _____ lbs Pulse: _____ B/P _____

Vision: Right 20/_____. Left 20/_____
Norm
Abnorm
Comments

Heart _____
 Lungs _____
 Back & Extremities _____
 Throat _____
 Lymph Glands _____
 Thyroid _____
 Teeth _____
 Hearing _____
 Abdomen _____
 Neurological _____

Urinalysis Sp Gr _____ Alb _____ Sugar _____ Micor _____

The following is recommended: Eye refraction _____ Audiometer Test _____

Recommended Special Medicines or Special Care _____

I have conducted a limited physical exam of the student named above and within the scope of this exam have found no obvious reason that the student may not participate in the school athletic program.

X _____
Physician's Signature
Date (Good until August 1, 2012)

Physician's Address _____ City, _____ State _____ Phone # _____