MARIAN HIGH SCHOOL
LEARN. SERVE. LEAD.

Health Questionnaire

(Parent/Guardian needs to complete)
Please Print!

Student:_____ Date of Birth: ____/____/____
Address:_____
City:_____ Zip_____ Phone Number:_____
Entering Grade:_____ Father's Name:
_____
Mother's Name:_____ Student Lives With:_____

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes List month/year	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above?
Please explain giving relevant dates:
_____

Please list any of the following with the month/year:

Operations:_____
Illnesses (Eye, ear, heart, stomach, kidney):
_____
Severe Injures (Head Injury, Fractures, etc.):
_____
Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?
_____
Please list any condition that should be considered in planning your child's school day:
_____
Allergies/Reactions:_____
Physician Name:_____ Phone #:_____
Dentist Name:_____ Phone # :_____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature_____ Date_____

MARIAN HIGH SCHOOL
LEARN. SERVE. LEAD.

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name:_____ Date of Birth: ____/____/____

Allergies_____

Current Medications: (List name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

Height:_____ Weight:_____ B/P:_____

Eyes: _____

Ears: _____ **Lead Level** (if indicated):_____

Nose: _____

Throat: _____ **Sickle Cell** (If indicated):_____

Chest: _____

Heart: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given:_____

Extremities: _____ Date Read:_____

Posture/Scoliosis: _____ Results:_____

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain:_____
- Please list any condition that should be considered in planning this child's school day:_____

Immunization Record: (Month/Day/Year)

DtaP/Tdap:

1._____
2._____
3._____
4._____
5._____

IPV (please indicate if OPV)

1._____
2._____
3._____
4._____

Hepatitis B:

1._____
2._____
3._____

M.M.R:

1._____
2._____

Varicella:

1._____
2._____

Hepatitis A:

1._____
2._____

Pertussis:

1._____

Menactra:

1._____

HPV:

1._____
2._____
3._____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature:_____Date_____