CAIRO AMERICAN COLLEGE

Health Office

Student Medical Examination: To Be Completed by a Medical Doctor

Name: _____ Birth date: _____ Sex: M F
Last, First Month/ Day/ Year

Grade: _____

History

Allergies: _____

Current complaints: _____

Past History: _____

Current Medications: _____

Examination

Pulse: _____B.P._____ Temp:_____ Weight:_____ Height:_____

	Normal	Abnormal		Normal	Abnormal
Growth & Nutrition			Cardiovascular		
Skin/Hair			Chest/ respiratory		
Head/Neck			Abdomen/Gastrointestinal		
Teeth			Orthopedic/Posture		
ENT			Nervous System		
Eyes			Urogenital		

Explain Abnormalities: _____

Physical Activity

	YES	NO	**If "No" please explain**
Is fully able to:			
Participate in competitive Sports?	_____	_____	_____
Participate in Physical Education?	_____	_____	_____
Free of any Physical Limitations?	_____	_____	_____

***Please note: A physician's letter is required in order to be excused from any physical education class.**

Required Vaccinations (attach copy of official records)

	Dose #1	Dose #2	Dose #3	Dose # 4	Last Booster
Poliomyelitis	*	*	*	*	
DPT/DT	*	*	*	*	*
MMR	*	*			
Hepatitis A	*	*			
Hepatitis B	*	*	*		

***Please give exact dates (Month, Day, Year)**

TB Skin Test: Date: _____ Result: POS NEG
OR
BCG Date: _____

_____ _____
Doctor's Name (PRINT) Doctor's Signature

_____ _____
Day/ Month /Year Doctor's Address/ Phone #