Notre Dame School
327 West 13th Street
New York, NY 10014

Summer Program Medical Form 2017

Name of Pupil: _____ Birth Date: _____

Parent's Name: _____ Tel.: _____

Home Address: _____

Business Address: _____ Tel: _____

Person to notify if unable to contact Parent: _____ Tel: _____

Physician: _____ Tel: _____

Address: _____

Significant past Illnesses, Injuries, Operations (Give Dates) _____

Allergies:_

Convulsions: _____

Special Medications: _____

Contagious Diseases (give dates if known, otherwise, check mark)

Measles☐ Mumps☐ Whooping Cough☐ Chicken Pox☐ German Measles☐ Scarlet Fever☐ Other☐

Physical Examination (Φ if normal; if abnormal "X" and explain below or on back)

Date						TESTS	DATE	DATE	DATE
Height						Type TBC			
Weight						Urine			
Blood Pressure, Pulse						HGB			
Vision Right						Other			
Glasses Left						Menarche at age:_____			
Without Right						Dysmenorrhea Severe: yes			
Glasses Left						no			
Hearing R									
L									
ENT						Comments & Recommendations from Physician: (Please date)			
Teeth									
Heart									
Lungs									
Breasts									
Abdomen									
Genitalia									
Musculo-Skeletal									
Posture and Feet									
Skin									
Speech									
Behavior									
Emotional Status									

Physician's Signature **Date of Exam** **Medical Society of the County of New York**

ACTIVITY: FULL☐ LIMITED☐ (If limited, explain on face of form)