## CAIRO AMERICAN COLLEGE

## **Health Office**

## Student Medical Examination: To Be Completed by a Medical Doctor

Name: Last, First Month/ Day/ Year Grade: History  Allergies: History: Current complaints: Past History:	Birth date:					Name:
History    History   History   History	Month/ Day/ Year		First		Last,	
Allergies:    Current complaints:   Current Medications:   Examination						
Current Complaints:    Current Medications:	tory	111				
Examination    Pulse: B.P.   Temp: Weight: Height:						Allergies:
Pulse: B.P. Temp: Weight: Height:    Normal   Abnormal   Cardiovascular   Normal   Abnormal   Cardiovascular   Normal   Abnormal   Chest/respiratory   Head/Neck   Abdomen/Gastrointestinal   Etheral   Orthopedic/Posture   ENT   Nervous System   EVES   Urogenital					mplaints:	urrent com
Pulse: B.P. Temp: Weight: Height:    Normal   Abnormal   Cardiovascular   Normal   Abnormal   Cardiovascular   Normal   Abnormal   Chest/respiratory   Head/Neck   Abdomen/Gastrointestinal   Etheral   Orthopedic/Posture   ENT   Nervous System   EVES   Urogenital					ry:	ast History
Pulse:						
Normal   Abnormal   Cardiovascular   Skin/Hair   Chest/ respiratory   Head/Neck   Abdomen/Gastrointestinal   Orthopedic/Posture   ENT   Nervous System   Eyes   Urogenital   Urogenital   Explain Abnormalities:    Physical Activity   Physical Activity   YES   NO   If "No" please explain   If "No						
Growth & Nutrition   Cardiovascular   Chest/respiratory   Chest/re	Weight: He	_ Temp:		_B.P		Pulse:
Skin/Hair   Chest/ respiratory   Head/Neck   Abdomen/Gastrointestinal   Creth   Orthopedic/Posture   ENT   Nervous System   Every   Urogenital   Creth   Orthopedic/Posture   ENT   Nervous System   Despression   Creth   Creth   Orthopedic/Posture   Creth   Orthopedic/Posture   Creth   Orthopedic/Posture   Creth   Orthopedic/Posture   Creth		Abnormal	Normal			
Skin/Hair   Chest/ respiratory   Head/Neck   Abdomen/Gastrointestinal   Creeth   Orthopedic/Posture   ENT   Nervous System   Urogenital   Explain Abnormalities:    Physical Activity   Physical Activity	diovascular	Ca			& Nutrition	Growth & 1
Teeth	est/ respiratory	Cl				
Explain Abnormalities:    Physical Activity				-	ck	Head/Neck
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 B  Poliomyelitis * * * * * * *  DPT/DT * * * * * * *  MMR * * * * * *  Hepatitis A * *  Hepatitis B * * * *  Please give exact dates (Month, TB Skin Test: Date: Result: POS NEG  Result: POS NEG	hopedic/Posture	Oı			-	Teeth
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 B  Poliomyelitis * * * * * * *  DPT/DT * * * * * *  MMR * * * *  MMR * * *  Hepatitis A * *  Hepatitis A * *  Hepatitis B * * * *  *Please give exact dates (Month, TB Skin Test: Date: Result: POS NEG	vous System	No				ENT
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Required Vaccinations (attach copy of official records)           Dose #1         Dose #2         Dose #3         Dose #4         Last B           Poliomyelitis         *         *         *           DPT/DT         *         *         *         *           MMR         *         *         *         *           Hepatitis A         *         *         *         *           Hepatitis B         *         *         *         *           *Please give exact dates (Month, Test: Date: OR			on?	al Educatio	te in competi te in Physica	Participate Participate
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Dose #1   Dose #2   Dose #3   Dose #4   Last B	h copy of official records)	Vaccinations (atta	Required V			
Poliomyelitis				Do		
DPT/DT					myelitis	Poliom
MMR	*	* 4	*	*		
Hepatitis A * * * * * * * * * * * * * * * * * *		*	*	*		
Hepatitis B * * * * * * * * * * * * * * * * * *		*	*	*		
*Please give exact dates (Month, TB Skin Test: Date: Result: POS NEG OR						
OR	*Please give exac					
	EG	_ Result: POS		ate:		
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	Blood group:				Date:	BCG D
Doctor's Name (PRINT) Doctor's Signature	Doctor's Sig		)	e (PRINT)	octor's Name	Doct
Day/ Month / Year Doctor's Address/ Phone #	Doctor's Addres			/Year	Day/ Month /	