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

Is fully able to:	YES	NO	If "No" please explain
Participate in competitive Sports?	_____	_____	______________________________________
Participate in Physical Education?	_____	_____	______________________________________
Any Physical Limitations?	_____	_____	______________________________________
Any Special Assistance Needed?	_____	_____	______________________________________

***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 #