



High School Programmes MEDICAL HEALTH FORM

Student's Name: _____

Address: _____

street

city

state/province

postal code

country

Date of Birth: _____ **Weight:** _____ **Height:** _____

day/month/year

A. HISTORY OF ILLNESS

Has the participant had any of the following illnesses/conditions:

Yes	No	
		Allergies
		Appendicitis
		Appendix removed
		Asthma
		Chicken Pox
		Diabetes
		Diphtheria
		Epilepsy
		Hepatitis (any form)
		Operation for Hernia
		Malaria
		Measles
		Mumps

Yes	No	
		Parasites
		Pneumonia
		Poliomyelitis (Polio)
		Rheumatic Fever
		Rubella (German Measles)
		Scarlet Fever
		Serious Cough
		Serious Headaches or Migraines
		Smallpox
		Tuberculosis
		Typhoid
		Vertigo/Dizziness
		Any other diseases

Any disease, impairment or abnormality of:

Yes	No	
		Blood or Endocrine System
		Bones or Joints
		Brain or Nervous System
		Ears or Hearing
		Eating Disorder
		Eyes or Sight
		Genito-Urinary System
		Heart or Blood Vessels
		Lungs, Respiratory System
		Other Abdominal Organs
		Personality/Behaviour
		Skin (Acne, Eczema, etc.)
		Stomach/Digestive System
		Tonsils, Nose or Throat
		Have Tonsils been removed?

Please give a full description of any disease or impairment mentioned above ("yes" response) including dates:

Allergies: Please list all allergies and the effects:

Allergy	Reaction	Life-Threatening?	Medication
_____	_____	Yes No	_____
_____	_____	Yes No	_____

Is there any medication that the student should NOT take?



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B. HISTORY OF IMMUNIZATIONS/VACCINATIONS

Student's Name: _____

1) Please indicate the **month and year** of all immunizations/vaccinations received by the student. The most recent must have occurred within the **past 10 years**.

Vaccine	Date	Date	Date	Date	Date
<i>Mandatory...</i>					
Diphtheria					
Polio					
Tetanus/Toxoids (Td)					
Smallpox					
Pertussis					
Tuberculosis (Manox Test)					
Mumps					
Rubella (German Measles)					
Measles					
<i>Other...</i>					
Typhoid					
Cholera					
Yellow Fever					
Other					
Other					

2. Has this student received the **BCG Vaccine for Tuberculosis**? No Yes: date

Please note that this may produce a positive result in a test for Tuberculosis. Most Canadian high schools will test incoming students for Tuberculosis, and the BCG Vaccine is not a guarantee of immunity. Students testing positive for Tuberculosis may be required to have a chest x-ray or prove that he/she does not have Tuberculosis, or in some cases may be required to take medication. The cost of the x-rays or medication must be paid by the student as medical insurance will not pay these costs.

C. MEDICATION & PHYSICAL ACTIVITY

1) Is the student currently taking medication for which a prescription is needed?

No Yes If yes, please name: _____

2) Is the student currently taking medication for which a prescription is not needed?

No Yes If yes, please name: _____

3) Recommendation for general physical activity in school:

Full physical activity including physical education classes

Modified activity because of _____

4) If the student is eligible and wishes to participate in the high school competitive sports programme, is there any factor in the student's physical condition which might pose a problem for him/her?

No Yes If yes, please explain: _____

D. FOR PHYSICIAN

In my opinion, the general state of the student's health is: Excellent Good Fair Poor

Comments: _____

I hereby certify that, to the best of my knowledge, the information above is true and correct.

Signature of Physician _____

Name of Physician _____

Date of Examination _____