FRIENDS SELECT

Due: August 7, 2009

PHYSICIAN'S FORM

(Physician's Signature Required)

2009-2010

Last Name **First Name and Initial** **Sex** **Grade**

Date of Birth: **Month** **Day** **Year**

IMMUNIZATION RECORD

To be completed by all new students and boosters updated by all other students.

DIPHTHERIA - TETANUS DIPHTHERIA - PERTUSSIS - TETANUS	DATE	ORAL POLIO (SABIN)	DATE
" Basic		TYPE I	
" Basic		TYPE II	
" Basic		TYPE III	
" Booster		Booster	
" Booster		Booster	
" Booster		Booster	
" Measles		HEPATITIS B (HBV)	
" Mumps		1	
" Rubella		2	
		3	

CHICKEN POX	DATE
Varivax	
Chicken Pox	

Notes

The state regulation requires month, day and year to be given for all immunizations. The measles, mumps, and rubella (German Measles) vaccine must be given after the first birthday.

State regulations require that all students entering must have had chicken pox or received the chicken pox vaccine prior to entering school.

TUBERCULIN TESTING

To be completed by all new students and those entering the 9th grade.

Tuberculin test on _____ Results _____

PHYSICAL EXAMINATION

To be completed by all new students and returning students entering 6th and 11th grades.

	Normal	Abnormal		Normal	Abnormal
General	_____	_____	Heart	_____	_____
HEENT	_____	_____	ABO	_____	_____
Chest	_____	_____	Extremities	_____	_____

Please explain any abnormal findings. _____

_____

Height _____ _____ Weight _____ _____ Hbt/Hct _____

Vision: Without glasses R 20/ _____L20/ _____ Hearing R_____ L _____ B.P. _____

With glasses/lenses R 20/ _____L20/

Does this student have a health condition (e.g., seizures, bleeding problems, diabetes, heart problems, asthma) or serious allergic reactions to foods, insect stings, drugs, dust, etc.which may require emergency action while in school,?

☐ Yes ☐ No Explain _____

_____

(over please)

PHYSICIAN'S FORM (con't.)

(Physician's Signature Required)

PHYSICAL EDUCATION AND ATHLETICS

To be completed yearly for all students.

Student's Name _____ **Grade:** _____

Is physically capable of participating in the physical education and interscholastic athletic programs (field hockey, soccer, basketball, swimming, cross country, crew, tennis, softball, baseball and wrestling) at Friends Select School for the coming school year and has our permission to do so. Any modifications to this permission are:

Modification _____ Reason _____

Modification _____ Reason _____

For grades **6-12 only**: May not wrestle below _____ body weight.

SCOLIOSIS SCREENING

To be completed by all new students and those entering the 6th and 7th grades.

☐ Scoliosis confirmed ☐ X-ray taken Recommendations: _____

_____ Degree of curve ☐ No x-ray taken _____

☐ No scoliosis _____

The following information is to be completed by the physician if the student requires medication at any time, including non-school hours.

Diagnosis(es) for which medication(s) is/are given: _____

Name(s) of Medication(s): _____

Dosage(s): _____

If medicine(s) is/are to be given DAILY, at what time? _____

If medicine(s) is/are to be given PRN (AS NEEDED), describe: _____

List significant side effects: _____

Other significant information: _____

PHYSICIAN COMMENTS:

Physician's Signature _____**Date** _____

Office Address _____**Phone** _____

Return by August 7, 2009 to:

Friends Select School
17th & the Benjamin Franklin Parkway
Philadelphia, PA 19103-1284

Tel: 215-561-5900
FAX: 215-864-2979