

**MCNICHOLAS HIGH SCHOOL**  
**Certificate of Medical Examination**

To be completed by family physician or clinic

This is to certify that:

\_\_\_\_\_ Sex F  
Student Name M Birthdate \_\_\_\_\_

was examined by me on \_\_\_\_\_,

was then free from disease, except \_\_\_\_\_,

has received the following immunization: (Give **complete** dates)

DPT: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup> \_\_\_\_\_

Td \_\_\_\_\_ or Tdap \_\_\_\_\_

Polio: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ 5<sup>th</sup> \_\_\_\_\_

MMR#1 \_\_\_\_\_ MMR#2 \_\_\_\_\_

HepB: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

Varicella: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ Chicken Pox Disease \_\_\_\_\_

Meningococcal Vaccine \_\_\_\_\_

HPV#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Scoliosis: Passed \_\_\_\_\_ Referred \_\_\_\_\_

TB Test: Date \_\_\_\_\_ Type \_\_\_\_\_ Result \_\_\_\_\_

(WITHIN 90 DAYS FOR STUDENTS FROM OUTSIDE THE U.S.)

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

is able to participate in all regular athletic and other activities

except: \_\_\_\_\_

Remarks: \_\_\_\_\_

Ohio state law requires that a student be excluded from school if the health record is not on file within 14 days of the first day of school.

\_\_\_\_\_  
Signature of Physician Required