McNICHOLAS HIGH SCHOOL
Certificate of Medical Examination

To be completed by family physician or clinic.

This is to certify that:

_____ _____ Sex M F
Student Name Date of Birth

Was examined by me on _____,

Was then free from disease, except_____,

Has received the following immunizations: (Please give **complete** dates)

DPT: 1st _____ 2nd _____ 3rd _____ 4th _____5th _____

Td_____ or Tdap_____

Polio: 1st _____ 2nd _____ 3rd _____ 4th _____5th _____

MMR #1_____ MMR #2_____

HepB: 1st _____2nd _____ 3rd _____

Varicella: 1st _____ 2nd _____Chicken Pox Disease _____

Menactra Vaccine 1st _____ 2nd _____

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

_____
Date Signed