Dominican Catholic School
114 Chalan Pale Ramon Lagu Rt.1
Yigo, Guam 96929
Tel. No. 653-3021/3140

MEDICAL CLEARANCE FORM

Note: Please submit on the first day of school.

Student: _____ Date: _____
Date of Birth: _____ Age: _____ Ethnicity: _____
Grade Entering: _____ School Year: _____
Home Address: _____
Home Phone: _____ E-mail Address: _____
Physician's Name: _____ Physician's Phone #: _____
Clinic's Address: _____
Father's Name: _____ Cell Phone #: _____
Mother's Name: _____ Cell Phone #: _____

Part 1: Physical Examination

Height _____ Weight _____ T _____ P _____ R _____
Blood Pressure_____ Vision: RT _____ LT _____ Hearing: RT _____ LT _____

Check Each Line :	Normal	Abnormal	Not Examined	Described suspicious /abnormal findings
General Appearance	[ ]	[ ]	[ ]	_____
Skin, Hair, Nails	[ ]	[ ]	[ ]	_____
Eyes: External				
(pupils-cornea)	[ ]	[ ]	[ ]	_____
Optic funds	[ ]	[ ]	[ ]	_____
Muscle Balance	[ ]	[ ]	[ ]	_____
Ears: External	[ ]	[ ]	[ ]	_____
Auditory acuity	[ ]	[ ]	[ ]	_____
Tympanic membrane	[ ]	[ ]	[ ]	_____
Tympanogram	[ ]	[ ]	[ ]	_____
Pure Tone	[ ]	[ ]	[ ]	_____
Nose, Mouth	[ ]	[ ]	[ ]	_____
Nose, Mouth	[ ]	[ ]	[ ]	_____
Pharynx, Larynx	[ ]	[ ]	[ ]	_____
Speech	[ ]	[ ]	[ ]	_____
Teeth, Gums	[ ]	[ ]	[ ]	_____
Neck, Lymph Nodes	[ ]	[ ]	[ ]	_____
Thyroid	[ ]	[ ]	[ ]	_____
Cardiovascular	[ ]	[ ]	[ ]	_____
Respiratory	[ ]	[ ]	[ ]	_____
Gastrointestinal	[ ]	[ ]	[ ]	_____
Genito-Urinary	[ ]	[ ]	[ ]	_____
Musculo-Skeletal	[ ]	[ ]	[ ]	_____
Scoliosis Screening	[ ]	[ ]	[ ]	_____

Part 2: Immunization Record: Please attach a copy of Updated Immunization Record.

PPD Test: Date: Given: _____ Result: _____

Please Check one: [ ] Perfectly healthy [ ] Specific Problem(s) Noted [ ] Handicapped
This child is physically fit to participate in physical education and/or athletic events and related activities. [ ] Yes [ ] No

Name of Physician (Print): _____ Signature_____ Date: _____
Clinic: _____ Email Address: _____
Health Insurance: _____ Policy No _____

Parental/Guardian Consent

I hereby give permission for the physician to examine my child so that he/she may obtain medical clearance to participate in athletic activities. Therefore, neither the examining physician nor the school is to be held liable for any abnormalities not detected in this examination. Permission is also granted to my child (Name: _____ to participate in athletic activities approved by the Physician as initiated below for school year: _____

Parent/Guardian Signature: _____ Date: _____

MEDICAL INFORMATION

(To be completed by parent or guardian)

Name: _____

Medical History: Please check "No" or "Yes" appropriately.	NO	YES
Allergies: Food, medication, etc.	[ ]	[ ]
Heart Problems or Heart Disease	[ ]	[ ]
Chest Pains	[ ]	[ ]
Asthma	[ ]	[ ]
Head injuries	[ ]	[ ]
Fractures	[ ]	[ ]
Weak joints or back problems	[ ]	[ ]
Taking medication : _____	[ ]	[ ]
Surgery	[ ]	[ ]
Blood Disorder	[ ]	[ ]
Hernia	[ ]	[ ]
Rheumatic Fever	[ ]	[ ]
Diabetes	[ ]	[ ]
Hearing Problems	[ ]	[ ]
Vision Problems	[ ]	[ ]
Convulsions/Seizures or Breathing Spells	[ ]	[ ]
Other serious injury or illness	[ ]	[ ]

To the best of my knowledge, the information on this page is accurate and complete.

Signature of Parent/Guardian _____ Date: _____