SAINT AUGUSTINE'S COLLEGE

P O Box N-3940 Nassau, Bahamas

Medical Form must be submitted by Aug 1

MEDICAL FORM / INFORMATION

Side 1 to be completed by the parent. (PLEASE PRINT)

STUDENT'S NAME LAST FIRST MIDDLE	SEX Male/Female	DATE OF BIRTH Month/Day/Year

MOTHER'S NAME	PHONE CONTACTS HOME WORK OTHER
ADDRESS House # & Street P. O. Box #	
FATHER'S NAME	PHONE CONTACTS HOME WORK OTHER
ADDRESS House # & Street P. O. Box #	

EMERGENCY CONTACT INFORMATION (Other Than Parent)

NAME / RELATIONSHIP TO STUDENT	PHONE CONTACTS HOME WORK OTHER
NAME / RELATIONSHIP TO STUDENT	PHONE CONTACTS HOME WORK OTHER

SIBLING INFORMATION (Names of brothers/sisters attending St. Augustine' College

PERSONAL PHYSICIAN

NAME	ADDRESS	PHONE CONTACT

EMERGENCY MEDICAL INFORMATION

PREFERRED HOSPITAL	INSURANCE COMPANY
PERTINENT MEDICAL INFORMATION (Medications, Allergies, asthma, impairments, seizures, etc.)	

In the event that reasonable attempts to contact me and/or other parent/guardian have been unsuccessful, I hereby authorize school representative to transport the student to the preferred hospital named above or any reasonably accessible hospital. I agree to meet the school representative in reasonable time.

Signature of Parent: Date:

Page 2 to be completed by the Physician

Student's Name (Last, First, MI) _____

TO BE COMPLETED BY PHYSICIAN:

Physical Examination: Each area of the examination form MUST BE COMPLETED with examination results.

Height:	Weight:	Blood Pressure:	Taking Medications?	Allergies?
Has Student had Eye Exam? YES NO Glasses? Contacts? YES NO YES NO	Audiogram Results:	Visual Acuity R 20/ L20/ With Correction? YES NO	Please List:	Please List:

Abdomen:		**Eyes:**	**Skin:**
		Ears:	**Head:**
Chest Contour:			
		Nose:	**Throat:**
Lungs:	**Heart:** **Rate & Rhythm**	**Neck:** **Lymph Glands:**	**Teeth:**
Genito-Urinary: **Hernia?** YES NO		**Thyroid:** **Range of Motion:**	**Mouth:**
Neurological: **(Balance-Coordination-Abnormal Reflexes)**		**Spine:** **Range of Motion:** **Curvature of Spine:**	**Extremities:**

HISTORY: Please state YES OR NO

Measles	Tuberculosis	Typhoid	Tetanus	Chickenpox	Whooping Cough	Polio	Mumps	Scarlet Fever

IMMUNIZATION

Vaccine Type	1st	2nd	3rd
Diphtheria, Tetanus & Pertussis			
Polio (Indicate IPV or OPV)			
MMR			
Booster			
Other			
Other			

_____

Please state any condition that may effect the student's participation in Physical Education.

Date of Examination:_____ Physician Signature:_____

Please incude official stamp with Name and/or Office