# Mt. Carmel Preparatory Academy

Please return this form dated, signed and stamped from a Medical Doctor to the guidance department.

## PART A: GENERAL INFORMATION

TO BE COMPLETED BY APPLICANT, PARENT OR GUARDIAN

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

ADDRESS (STREET NAME) _____ HOUSE# _____

P.O.BOX _____ TELEPHONE (HOME) _____ (WORK) _____

_____ _____ SEX: MALE { } FEMALE { } _____

MM/DD/YY AGE NATIONALITY

DATE OF BIRTH

## PART B: FAMILY MEDICAL HISTORY

Has any of your immediate family had any of the following?

| | | | |
|---|---|---|---|
| Tuberculosis | Yes [ ] No [ ] | Diabetes | Yes [ ] No [ ] |
| Heart Disease | Yes [ ] No [ ] | Cancer | Yes [ ] No [ ] |
| High Blood Pressure | Yes [ ] No [ ] | Emotional Disorder | Yes [ ] No [ ] |

## PART C: PERSONAL HSTORY

Allergies To: FOOD - (List Them) _____

DRUGS – (List Them) _____

MEDICINES ROUTINELY TAKEN: _____

**HAVE YOU EVER HAD OR SOUGHT MEDICAL ASSISTANCE FOR ANY OF THE FOLLOWING?**

| | | | |
|---|---|---|---|
| Asthma | Yes [ ] No [ ] | Pneumonia | Yes [ ] No [ ] |
| Diabetes | Yes [ ] No [ ] | Prolonged Depression | Yes [ ] No [ ] |
| Heart Disease | Yes [ ] No [ ] | Rheumatic Fever | Yes [ ] No [ ] |
| Hepatitis | Yes [ ] No [ ] | Ulcers | Yes [ ] No [ ] |
| High Blood Pressure | Yes [ ] No [ ] | Urinary Infection | Yes [ ] No [ ] |
| Kidney Disease | Yes [ ] No [ ] | Venereal Disease | Yes [ ] No [ ] |
| | Severe Menstrual Cramps | Yes [ ] No [ ] | |

LIST ANY MAJOR ILLNESS

_____

LIST ANY MAJOR SURERY

_____

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**PART D: To be completed by personal physician.**

PLEASE WRITE: [N] Normal or [A] Abnormal

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Eyes | [ ] | Heart | [ ] | Skin | [ ] | Temperature | [ ] |
| Ears | [ ] | Vascular | [ ] | Lymph Nodes | [ ] | Pulse | [ ] |
| Nose | [ ] | Lungs | [ ] | Nutrition | [ ] | Respiration | [ ] |
| Mouth | [ ] | Breast | [ ] | Neurological | [ ] | B/P | [ ] |
| Throat | [ ] | Abdomen | [ ] | Spine | [ ] | Height | [ ] |
| Thyroid | [ ] | Genitalia | [ ] | Vision | [ ] | Weight | [ ] |
| Chest | [ ] | Rectal | [ ] | Behaviour | [ ] | Urine | [ ] |
| Stool | [ ] | Muscular | [ ] | Skeletal | [ ] | | |

**PART E: BLOOD INVESTEGATIONS**

FBC: _____ Hb: _____

Assessment _____

Mantoux- Date Given _____/_____/_____ (MM DD YY) Results: _____

REQUIRED IMMUNIZATION

**(If parent does not have the immunization card this section can be filled out through the school nurse or administrator also)**

| | | | | | |
|---|---|---|---|---|---|
| D.P.T Primary series completed | _____/_____/_____ (MM DD YY) | Signature _____ | POLIO: Primary series completed | _____/_____/_____ (MM DD YY) | Signature _____ |
| Last D.T Booster | _____/_____/_____ (MM DD YY) | Signature _____ | (Repeat if over 10 years duration) | _____/_____/_____ (MM DD YY) | Signature _____ |
| MMR. Vaccine- 1st Dose | _____/_____/_____ (MM DD YY) | Signature _____ | 2nd Dose | _____/_____/_____ (MM DD YY) | Signature _____ |
| Measles Vaccine | _____/_____/_____ (MM DD YY) | Signature _____ | Rubella Vaccine | _____/_____/_____ (MM DD YY) | Signature _____ |

_____
PHYSICIANS NAME

_____
PHYSICIANS SIGNATURE

_____
BUSINESS PHYSICIANS ADDRESS

_____
PHYSICIANS TELEPHONE #

_____
BUSINESS STAMP

_____
MM/DD/YY
(DATE)