SAINT IGNATIUS

Cleveland · Jesuit · 1886

- ***Only this form is accepted and required for ALL freshmen and transfer students.***
- Must include an up-to-date IMMUNIZATION RECORD
- **Please SCAN and SEND completed forms** to Freshmanforms@ignatius.edu

Saint Ignatius High School Freshman/Transfer PHYSICAL EXAMINATION FORM

This form is NOT the OHSAA Physical Form - That form must be completed and turned into the ATHLETICS Department if your son is participating in Athletics.

PLEASE READ BEFORE YOUR APPOINTMENT

If your student has any of the health concerns indicated below with a *, please print the **additional medical forms** in advance and have the healthcare provider complete and sign. These medical forms are found at www.ignatius.edu/school-nurse.

Student Name: _____ DOB: __/__/____ ID#:_____
(last, first, middle initial)

Ht. Wt. _____ BMI% _____ Intervention _____ B/P _____ Pulse _____ Resp. _____

Vision: L _____ R _____ referred _____ Hearing: L _____ R _____ referred _____

System	Findings: Normal / Abnormal + Explanation
Gross dental(teeth -gums)	
Head/scalp/skin	
Eyes/Ears/Nose/Throat	
Chest/Lungs/Heart	
Abdomen	
GI, hernia	
Musculoskeletal, scoliosis	
Neurological	

*____ This student has **additional history/medical concerns***, e.g. chronic/major illnesses, hospitalization, surgeries, allergies, or a condition that requires medication during school hours.* Please explain:

_____

*_ This student has a **health condition that may require emergency action at school***, e.g. seizures, serious allergies, asthma, diabetes. Please submit action plan found https://www.ignatius.edu/school-nurse to school nurse* Please explain:

_____

*____ This student requires **medication at school**.* Please list medications: _____

_____

_____

❖ ***Please check one:***

____ This student may participate fully in all school activities including physical education.

____ This student needs a restriction/adaptation to participate in school activities include physical education. Please explain the reason and the restriction(s):

_____

Healthcare Provider Signature _____ **Phone number** _____

OFFICE STAMP **Date** _____