SAINT RAYMOND HIGH SCHOOL FOR BOYS
2151 ST. RAYMOND AVENUE
BRONX, NY 10462
718-824-5050

STUDENT NAME DATE OF BIRTH

STREET ADDRESS FLOOR/APT #

CITY STATE ZIP CODE PHONE NUMBER

Parents or Guardians: The Public Health Law, Section 2164, states that children may not attend school without a certificate of immunizations. **NO STUDENT WILL BE ADMITTED TO ST. RAYMOND HIGH SCHOOL WITHOUT THIS REQUIRED PHYSICAL EXAMINATION AND THE COMPLETION OF THE IMMUNIZATION RECORD.**

TYPE OF IMMUNIZATION	ENTER EXACT DATES					
Tdap						
Diphtheria Pertussin Tetanus or (DPT) (4 required)						
Polio: (3 required)						
MMR						
Measles (2 required)						
Mumps (1 required)						
Rubella (1 required)						
Hep "B" (3 dose series)						
HEP "A"						
HPV – 4 Gardasil						
MenactraT/MCV4						
HIB						
Other						

MANTOUX – **Must include date of last test**

Date of last Tuberculin test _____ Positive_____ Negative_____

(If positive give x-ray findings): _____

Blood Pressure _____ Weight _____ Height_____

Varicella Disease: _____ Vaccine Dates: _____ _____

Health Problems: Has child had any of the following conditions. Please check and indicate date of illness.

Permission to self administer medication: _____ YES _____ NO

_____ Asthma * Specify medication _____
_____ Diabetes* Specify medication _____
_____ Measles _____
_____ Mumps _____
_____ Rubella _____ (German Measles)
_____ Allergies -Specify _____
_____ Frequent Colds _____
_____ Ear Infections _____
_____ Hearing Problems _____
_____ Seizures _____
_____ Heart Conditions _____
_____ Blood Pressure High/Low _____
_____ Anemia _____
_____ Orthopedic Problems Specify _____
_____ Headaches _____
_____ Eye or Vision Problems _____
_____ Operations (Please specify and give dates) _____
_____ Hospitalizations (Please specify reasons and dates) _____
_____ Other Health Problems: _____

RECOMMENDATIONS FOR PHYSICAL ACTIVITY IN SCHOOL:

_____Full Physical Activity including Gym
_____Modified Physical Activity
(Specify) _____
_____
_____

Special Recommendations or modifications in pupil's program (Specify)

SPECIALLY APPROVED FOR:

Intramural Sports _____ Soccer _____ LaCrosse_____ Handball_____

Track and Field _____ Hockey _____ Baseball_____ Bowling _____

Basketball_____ Weight Room_____ Golf_____ Outdoor Club _____

_____
Signature of Physician

_____
Date of Exam

_____
Print or Stamp Name and Address of Physician

_____
Telephone Number