

MEDICAL EVALUATION FORM ~ DUE AUG 1 ~ REQUIRES PHYSICIAN'S SIGNATURE

ALL new AND returning students must submit this form by August 1.

Student Name _____ DOB ___ / ___ / ___ 2019-20 Grade: _____

The student named above has had a complete history and physical examination at our office including tuberculin testing, appropriate laboratory examinations and tests of vision and hearing. Findings for this child are indicated as follows:

1. **Date of most recent tuberculin test** _____ / _____ / _____

Result: Positive Negative

2. **The pupil has the following, which may adversely affect his educational experience** (If *there is not enough room provided to explain health issues, please attach additional sheet(s):*

- a. Visual problem _____
- b. Hearing problem _____
- c. Speech or language problem _____
- d. Other physical illness, impairment, or allergies _____
- e. Mental, emotional or behavior problem _____
- f. Scoliosis _____

COMMENTS & RECOMMENDATIONS:

3. **The pupil has a health condition, which may require emergency action while he is at school.** *(Please specify, e.g., seizures, diabetes, heart issue, * allergy, * asthma, etc.):*

COMMENTS & RECOMMENDATIONS:

*** Note to students requiring an Epi-Pen and/or inhaler: Please also provide the Epi-Pen and/or Inhaler Authorization Form(s) by Aug 1. Both require physician's signature. The actual Epi-Pen(s) and/or Inhaler(s) can be provided to Mater Dei on the first day of school – please see forms for requirements.**

4. **This pupil is on long-term medication. Please specify** _____

5. **Except as noted above, the pupil is in good physical and mental health, is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all school activities, including PE. I find this pupil physically able to compete in supervised activities listed below which are NOT **CROSSED OUT:****

- | | | | | |
|---------------|------------|---------------|----------|------------|
| Baseball | Basketball | Cross Country | Football | Ice Hockey |
| Indoor Hockey | Lacrosse | Soccer | Softball | Tennis |
| Volleyball | Wrestling | | | |

PHYSICIAN SIGNATURE

_____/_____/_____
DATE

_____-_____-_____
TELEPHONE

**Required for ALL new & returning students
DUE ANNUALLY BY AUGUST 1**

Email, mail or fax by AUG. 1st:
Mater Dei School, 9600 Seven Locks Rd., Bethesda, MD 20817
Fax: 301-365-2710 Email: Health@MaterDeiSchool.NET