

Wyoming Seminary

Founded 1844

College Preparatory School
Kingston, Pennsylvania 18704-3593

Medical History – To be completed by parent or guardian before going to your physician.

Student's name: _____ Sex: _____ M _____ F
Last First Middle

Home Address: _____ Date of Birth: _____
Street City State Zip

Father's Name: _____ Home phone: () _____
Last First Middle

Address: _____ Work Phone: () _____
Street City State Zip

Mother's Name: _____ Home phone: () _____
Last First Middle

Address: _____ Work Phone: () _____
Street City State Zip

Family Medical History

List any disease which have occurred in the family, such as:

Tuberculosis _____

Diabetes _____

Epilepsy _____

Asthma _____

Other _____

List the death of either parent or sibling. Please include cause of death and date: _____

Student's Medical History

Congenital defects	Yes	No	Measles	Yes	No	Tuberculosis	Yes	No
Allergies			Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Operations		
Drug	<input type="checkbox"/>	<input type="checkbox"/>	Infectious			Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Illness			Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			
German Measles	<input type="checkbox"/>	<input type="checkbox"/>						

Immunization record. Enter month/day/year.

The following are required by law for admission to Pennsylvania schools. Returning students list boosters only.

Diphtheria-Tetanus-Pertussis DTP	1 / /	2 / /	3 / /	Booster 4 / /	Booster 5 / /
or Diphtheria-Tetanus (DT)	1 / /	2 / /	3 / /	Booster 4 / /	Booster 5 / /
Oral Polio (OPV)	1 / /	2 / /	3 / /	Booster 4 / /	Booster 5 / /
Measles(Rubeola or Red*) *Must be administered at age 12 mos. or older.	1 / /	2 / /	Or Measles Serology Date _____ Blood Titer_____		
German Measles(Rubella*) *Must be administered at age 12 mos. or older.	1 / /	2 / /	Or Rubella Serology Date _____ Blood Titer_____		
Mumps * *Must be administered at age 12 mos. or older.	1 / /	2 / /	Or Mumps disease diagnosed by a physician Date :		
Required –Hepatitis B	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Or Chicken Pox diagnosed by physician: Date:		

Additional information

A. Has student's physical activity been restricted in the past five years

Yes No

Give reasons and duration _____

B. Has student received treatment or counseling for a nervous conditions, personality disorder,
controlled substance abuse, or emotional problems.

Give reasons and duration _____

C. Has the student had any illness or injury or been hospitalized other than already noted.

Give reasons and duration _____

In the event the student lacks the documentation of the needed immunizations, I give the health and medical care officials of Wyoming Seminary permission to administer inoculations as necessary. I also give permission for the administration of prescribed or over the counter medication deemed necessary for their care and treatment.

I give my permission to Wyoming Seminary to share this information, as needed, in order to ensure the health and safety of my child.

Parent's Signature

Date

Physician's Signature(Acknowledging review) Date

Physician's Report

Please have physician return this form to: Dean of Students, Wyoming Seminary,
201 North Sprague Avenue, Kingston, PA 18704-3593

To the examining Physician- Please review the student's medical history and complete this physician's form, commenting on all positive answers. This information you provide will be used only as an aid to student health care.

Student's name: _____

_____ Last
_____ First
_____ Middle

Physical Examination

Height(without shoes):	Urinalysis* Sugar _____	Visual Acuity Without Glasses R _____ L _____	Tuberculosis skin test
Weight(indoor clothing):	Albumin _____	With Glasses R _____ L _____	Required of all new students Date _____
Blood Pressure:	HIV* _____ CBC* _____	Color Vision _____	Result _____ If positive, chest x-ray required. Date _____
Pulse(resting):	* if indicated	Hearing R _____ L _____	Result _____

Check List	Normal	Abnormal	Explanations
Skin			
Head and Neck			
Eyes, ears, nose and throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Musculoskeletal			
Neuropsychiatric			
Metabolic/Endocrine			

Is the student at present under medical treatment or receiving any medication? Yes No

Is so, please specify treatment, medication and dosage: _____

Females only: Dysmenorrhea Yes No Medication Prescribed _____

Emotional and/or psychiatric conditions: _____

Recommendation for physical activity (physical education, intramural sports) :

Unlimited Limited Not at all Explain in limited or not at all : _____

Remarks: _____

Please review the first two pages of this document, taking special note of immunization record, and then sign.
Thank you for the time you have taken in completing this form. Your efforts are genuinely appreciated.

Physician's Signature

Date

Please print last name

Address