

GOVERNOR'S HONORS PROGRAM HEALTH CERTIFICATE



IMPORTANT...DO NOT MAIL: Please bring this form with you to registration on June 26, 2011. You will not be admitted to the dormitory until this form is completed and signed by your physician.

---This Form *Must* be Completed and Signed by a Physician---

Patient Information				
First Name	Middle Name	Last Name		
Home Address (Street/Route/Post Office Box)			City	State Zip
Home Phone () - -	Birth Date (MM/DD/YY)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Health Information				
Height:	Weight:	Pulse:	BP: /	

Physical Evaluation	Normal	Abnormal	Comments/Explanation if Abnormal
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart Murmurs: Y <input type="checkbox"/> N <input type="checkbox"/>			
Pulse			
Lungs			
Abdomen			
Genitourinary (Males Only) Hernia: Y <input type="checkbox"/> N <input type="checkbox"/>			
Skin			
Skeleton			
Feet			

Required Immunizations: Certification of immunization for measles, mumps and rubella is required of all participants. Failure to submit this information will prevent program participation.			
Measles: 1st Date:	Measles: 2nd Date:	Mumps Date:	Rubella Date:

Recommended Tests/Immunizations (Not Required)	
Tuberculin Skin Test Date: Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	If positive, chest x-ray required. Date: Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Diphtheria/Tetanus Booster recommended within 10 years. Date:	Polio Date completed series:
Hepatitis A Vaccine 1 st Date: 2 nd Date: 3 rd Date:	Hepatitis B Vaccine 1 st Date: 2 nd Date: 3 rd Date:
Hepatitis A/B Combination Vaccine 1 st Date: 2 nd Date:	Chicken Pox Vaccine Date:

Allergies to Medication:	Latex Allergy? Y <input type="checkbox"/> N <input type="checkbox"/>

Does patient take any medication on a regular/daily basis? If yes, list name and dosage:

Comments – Please provide information relative to student’s health that should be brought to the attention of the school physician and the physical education staff.

(Name of Physician – Print or Stamp)

(Date)

(Signature of Physician) **M.D. or D.O.**

(Name of Medical Office)

(Office Street Address)

(City, State, Zip)

(Office Area Code and Phone Number)