SOUTH CAROLINA GOVERNOR'S SCHOOL for Science & Mathematics

Please return this completed form to Health Services by August 1, 2018.

MEDICAL EXAMINATION/SELF HISTORY

Section A (to be completed by the parent/guardian and reviewed by Health Care Provider)

Student's Name (please print)_____**Today's Date**_____

Date of Birth _____ **M**_____ **F**_____ **List ALL allergies & your reactions to them:**

Medication allergy: _____

Food Allergy: _____ **Dust/Pollen/Mold**: _____

Latex Allergy: _____ **Animals/Insects**: _____

Do you carry an EPI-pen? YES / NO If yes,do you know how to use it? YES / NO

Do you receive allergy shots? YES/NO If yes, how often? _____

SECTION A: COMPLETED BY PARENT & REVIEWED BY PHYSICIAN

If your child has ever had any or has any of the following conditions or symptoms, circle all that apply.

Asthma	Cancer	Head Injury (concussion)	Inflammatory Bowel	Mononucleosis	Severe Menstrual cramps
Attention Deficit Disorder (ADD or ADHD)	Chest pain/shortness of breath	Hearing loss	Irregular Periods	Neck problems	Sickle Cell Trait
Arthritis	Depression	Heartburn or Gastric reflux	Kidney Infections	Neurological disorder	Skin problem
Anxiety/Panic Attacks	Diabetes	Heart murmur	Kidney Stones/Disease	Psoriasis	Sleep disorder
Asperger's Disorder	Eating Disorder	Heart problem	Learning differences	Physical disability	Thyroid Disorder
Back problems	Epilepsy/Seizures	Hepatitis	Liver disease	Pneumonia	Ulcer/Stomach or Duodenal
Bipolar Disorder	Eye injury/disease	Hernia	Lung disease	Psychological Disorder	Urinary Tract Infections
Blood disorder/Anemia	Frequent nosebleeds	HIV/AIDS	Lupus	Recurrent Sinusitis	Visual Impairment
Bone/Joint problems(knees, ankles, shoulders, wrists, spine)	Frequent Headaches	Hypoglycemia (low blood sugar)	Migraines	Self-injurious behavior	Other:

Please provide details of conditions circled above and list any not mentioned: (include medications, surgeries, treatments)_____

_____

SOUTH CAROLINA GOVERNOR'S SCHOOL
for Science & Mathematics

Please return this completed form to Health Services by August 1, 2018.

PHYSICAL EXAM BY HEALTH CARE PROVIDER

Section B (Please review Section A on the front of this form)

	Color Vision		**Endocrine System**		**Neuro-Psychiatric**		**Bones & Joints**
	Eyes		**Lungs & Chest**		**Abdomen**		**Feet**
	Ears		**Heart:_____**		**Hernia**		**Nose**
	Musculo-Skeletal System		**Vascular System**		**Skin**		**Other**

Ht _____ Wt _____ B/P _____ R _____ Vision: (Rt)_____(Lt) _____ (Both)_____

1. **Y N** Physical examination is within normal limits. **(If abnormal, please attach a copy of your reports)**
2. **Y N** Is this student currently under your care and/or on medication? **(If so, please list and explain)**

   _____

   _____
3. **Y N** Do you consider this student physically and/or emotionally capable of handling a challenging, rigorous residential high school environment? **(If no or doubtful, please explain)**

   _____

   _____
4. **Y N** Is this student physically and emotionally capable of participating in sports, physical activities, exercise programs, etc. **(If no or any restrictions, please attach a letter report listing full details of any limitations and why)** ***Please complete and sign Preparticipation Physical Evaluation***
5. **Y N** Does this student have any dietary restrictions or food allergies that would make eating in the residential dining hall difficult? If **YES**, please explain. _____

   _____

   _____

X_____ (____)_____ (____)_____

Signature of Examining Physician **Telephone Number** **Fax Number**

_____ _____ **Date** _____

Printed Name **Address/Stamp**

This form is required, yearly, for all GSSM students and is to be completed by the student's Health Care Provider, as indicated. Under HIPAA & FERPA guidelines, all information is strictly confidential and will be available only to personnel on a need-to-know basis.