San Marcos Academy

Lower School Medical Certificate

Student Name: _____Date of Birth: _____Grade: _____

Address: _____ Home Phone: _____
Street City Zip

Father's Name: _____ Emergency Phone: _____

Mother's Name: _____ Emergency Phone: _____

Health History

Drug Allergies: _____Environmental Allergies: _____

Insect Allergies: _____ Food Allergies: _____

Asthma: _____ Seizure Disorder: _____ Diabetes _____

Orthopedic: _____ Psychological: _____ Other: _____

Ongoing Medications: _____

Please attach Immunization Records

***I certify that I have examined the above student in the past year and recommend that (he/she) is physically able to participate in all supervised activities and sports.**

Exceptions: _____

Signature of Examining Physician: _____ Date: _____

Printed Name of Physician: _____ Phone: _____