



PARENT'S REPORT OF MEDICAL HISTORY

Note: This side of form should be completed by parents prior to physician's examination.

Student's name _____ Birth date _____

Father's name _____ Mother's name _____

Social Security No. _____ Social Security No. _____

Father's condition of health: _____

Mother's condition of health: _____

Brothers (ages and health) _____ Sisters (ages and health) _____

GENERAL CONDITION OF HEALTH (Please check or explain any of the below noted recently.)

Abdominal pains _____	Frequent sore throat _____	Muscle cramps _____
Allergies _____	Frequent boils, styes, infections _____	Nosebleed _____
Crippling conditions _____	Frequent urination _____	Persistent cough _____
Dental defects _____	How often? _____	Poor vision _____
Diarrhea _____	Frequent leg pains _____	Parasites (worms) _____
Dizziness _____	Headaches _____	Speech difficulty _____
Earaches _____	Hearing difficulty _____	Shortness of breath _____
Fainting spells _____	Hernia _____	Tires easily _____

How many colds has student had in last 12 months? _____

PERSONAL RECORD (Please answer all of the following.)

Does student have any disabilities or deformities? _____

Is student shy? _____	Overactive? _____	Bites fingernails? _____
Does he (she) suck thumb? _____	Have excessive fears? _____	Have temper tantrums? _____
Does he (she) like school? _____	Plays well with others? _____	Eat breakfast? _____

Does student take a nap? _____ time: _____

When is his (her) regular bedtime? _____ Rising time? _____

I understand that all pupils who show symptoms of communicable disease are to be excluded from classes until readmission is acceptable to school authorities. I will cooperate by keeping my child home during such times and informing the school of such.

Date: _____ Signature of Parents: _____

PHYSICIAN'S REPORT OF HEALTH

Please review the student's history and complete the physician's form. Please comment on all positive answers.

Student's name _____ Male _____ Female _____

Birth date _____ Weight _____ Height _____ ft. _____ inches

Medical History (age at onset)

Asthma _____ Heart Disease _____ Pneumonia _____

Chicken Pox _____ Measles (type) _____ Rheumatic Fever _____

Convulsions _____ _____ Scarlet Fever _____

Diabetes _____ _____ Whooping Cough _____

Diphtheria _____ Mumps _____ Other _____

Discharging Ears _____ Polio _____ _____

Immunizations (enter dates given)

D.P.T. 1. _____ 2. _____ 3. _____ 4. _____ DT _____

Polio 1. _____ 2. _____ 3. _____ Booster _____

Rubella Vaccine _____

Tetanus _____

Measles _____

Physical Examination:

_____ Eyes	_____ Chest
_____ Skin and Hair	_____ Heart
_____ Ears	_____ Abdomen
_____ Nose and Throat	_____ Genitalia
_____ Mouth and Teeth	_____ Hernia
_____ Coordination	_____ Skeletal

Recommendations for Physical Activities:

Do you have any recommendations for care of this student?

Is the student now under treatment for any medical or emotional disorder? If so, please specify.

Physician's signature _____

Physician's name (print or type) _____

Address _____

Phone No. _____ Date of examination _____