Department of Health Services

Medical History

Name_____ Birthdate_____

Parent or Guardian _____

Disease	Date	Disease	Date
Chicken Pox	_____	Whooping Cough	_____
German Measles	_____	Measles	_____
Mumps	_____	Other	_____

Mother's health during pregnancy:

Was there illness or complication at birth? Explain _____ Date_____

Has your child had a serious accident? Explain _____ Date_____

Has your child ever been in the hospital or had an operation? Explain _____

_____ Date_____

Does your child have:

Allergy (specify) _____

Seizures _____

Bronchitis or asthma _____

Diabetes _____

Other _____

Does anyone in the family have:

Allergy (specify) _____

Seizures _____

Bronchitis or asthma _____

Diabetes _____

Tuberculosis _____

Other _____

DENTAL EXAMINATION

I have examined the teeth of _____ Date_____

Dental correction necessary_____

Dentist's corrections completed_____

Mouth in good condition_____

Dentist Signature_____

Print Name_____

Address_____

Name_____

**History of Tuberculosis ☐ NO ☐ YES Test if Needed: Date_____Result_____

Sickle Cell Anemia Test _____ Lead Poisoning Test_____

Physical Examination and Immunizations

- Diphtheria, Tetanus & Pertussis 1_____ 2_____ 3_____ 4_____ 5_____
- Polio 1_____ 2_____ 3_____ 4_____
- TDAP (Grade 6-12) 1_____
- MMR 1_____ 2_____
- Menactra 1_____ 2_____
- Hepatitis B 1_____ 2_____ 3_____
- Varicella 1_____ 2_____
- Hepatitis A 1_____ 2_____
- HPV (recommended) 1_____ 2_____ 3_____

(Please check if normal or abnormal; if abnormal, describe below)

	Normal	Abnormal
Physical Development		
Nutritional Development		
Skin		
Hair and Scalp		
Eyes (except Vision)		
Ears (except Hearing)		
Nose		
Throat		

	Normal	Abnormal
Lungs		
Heart		
Abdomen		
Extremities		
Orthopedic		
Scoliosis		
Other Defects		
Not Listed		

Is your child under medical treatment? ☐ NO ☐ YES

If yes, state reason _____

Treatment_____

Physical Fitness Evaluation

Please check on of these recommendations:

- ☐ I recommend the regular school program (Physical Education including running, basketball, tennis, etc.)
- ☐ I recommend modified activity (Specify degree and reason [Physical Education including ping-pong, throwing, etc])
- ☐ I recommend exclusion from physical education. **Reason must be given.**

_____

_____

Recommendations for modified activity or exclusion are effective for the current school year only, unless specified below. Comments and recommendations.

_____

_____

Date _____ Physician Signature_____

Print name and address _____

**required for high school entrance for high risk patients

HD 102 8/2016