



MEDICAL HISTORY

Child's Last Name: _____ Child's First Name: _____
Home Address: _____ Date of Birth: _____

Medical Insurance
Company: _____
Policy # _____ Name of Subscriber: _____

TO BE COMPLETED BY PARENT -- Past History

Chicken Pox _____	Allergies _____	Glasses or Contacts _____
Visual Defects _____	Asthma _____	Seizures _____
Hearing Problems _____	Absent Organ _____	Operations _____
Serious Accidents _____	Heart Disease _____	Fractures, Dislocations _____

Other significant illnesses or handicapping conditions _____
Currently on any medications _____

TO BE COMPLETED BY PHYSICIAN -- Physical Examination

_____	_____	_____	_____	_____	_____	_____
Height	Weight	Blood Pressure	Vision R	Vision L	Hearing R	Hearing L

Please note any abnormalities in the following systems:

Head, Ears, Nose, Throat _____	Color Vision _____	Musculoskeletal _____
Respiratory _____	Eyes _____	Metabolic, Endocrine _____
Cardiovascular _____	Hernia _____	Neurophysiatrie _____
Gastrointestinal _____	Genitourinary _____	Teeth _____
Skin (including Lymph Nodes) _____		

General Condition _____

Immunizations given since last exam _____

Should this child have restrictions in play or physical activities? _____

Reasons or Recommendations _____

In your opinion, does this child have a handicapping condition? _____

If so, please specify _____

Signature of Examining Physician _____ Date of Exam _____

Print Name of Examining Physician _____ Address _____

220 Winton Road South Rochester, New York 14610 716-442-8340