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 - History

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

More detail on above:

Other significant illnesses or handicapping conditions:

Current 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 ______
Respiratory ______
Cardiovascular ______
Gastrointestinal ______
Skin (including Lymph Nodes) ______

Color Vision ______
Eyes ______
Hernia ______
Genitourinary ______

Musculoskeletal ______
Metabolic, Endocrine ______
Neurophychiatric ______
Teeth ______

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

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