MEDICAL – PHYSICAL RECORD

(Information on this form may be shared with appropriate personnel for health and educational purposes)

Student's Name: ______________________________ **Sex:** _________________ **Birthdate:** _________________

MEDICAL HISTORY ***(To be completed by parent/guardian)***

	YES	NO	MONTH/YEAR		YES	NO	MONTH/YEAR
Chicken Pox				Heart Disease			
Measles				Asthma			
Rubella (German Measles)				Diabetes			
Mumps				Epilepsy			
Scarlet Fever				Tuberculosis			
Rheumatic Fever				Ear Infections/Tubes			
Concussion				Sickle Cell			

Date of Last Eye Doctor Visit: _________________________ Does the Child Wear Glasses? _______________________

Injuries (Describe): ____ Year(s): ________________

Surgeries (Describe): ____ Year(s): ________________

Other Medical Conditions: ____

Medication(s): (please list medication(s) and reason for use): ____

IMMUNIZATIONS ***(To be completed by the Doctor – Please include the month, day, and year for each dose)***

	DTaP	Hepatitis B	Polio	Tdap	MMR	Varicella	MCV4	Hepatitis A
1st Dose								
2nd Dose								
3rd Dose								
4th Dose								
5th Dose								

Medical Exemption: YES or NO

Reason: ____

PHYSICAL EXAMINATION ***(To be completed by the Doctor)***

	Normal	Abnormal		Normal	Abnormal
Height			Cardiovascular		
Weight			Respiratory		
Blood Pressure			Gastrointestinal		
Heart Rate			Throat, Glands		
Eyes			Urinalysis		
Ears			Genito/Urinary		

Special Diet Needs: ____

Date: ____ Physician's Printed Name: ______________________________

Physician's Signature: _______________________________________