

STUDENT MEDICAL HISTORY & PHYSICAL
For New Students Only

Student's Name _____ Date of this form _____

Address _____

Birth date _____ Grade _____

Parent/Guardian Name _____ Phone No. _____

I. HEALTH HISTORY - TO BE FILLED BY STUDENT/PARENT

Diseases: State Year of Problem

Chicken Pox _____	Mumps _____
Hepatitis _____	Scarlet Fever _____
Measles(Hard) _____	Whooping Cough _____
Measles(Rubella) _____	Others _____
Meningitis _____	_____
Mononucleosis _____	_____

CHRONIC AND RECURING ILLNESSES: STATE YEAR AND CLARIFY WHERE NECESSARY

Animal allergy _____	Diabetes _____
Drug allergy _____	Ear infection _____
Food allergy _____	Eye infection _____
Hay fever _____	Heart disease _____
Insect sting allergy _____	Hemophilia _____
Asthma _____	Bone/muscular disease _____
Colds _____	Pneumonia _____
Other allergy _____	Pneumatic fever _____
Seizures _____	Skin infections _____
Strep infection _____	Tuberculosis _____
Stomach ulcers _____	Skin ulcers _____
Others _____	_____

OPERATIONS AND INJURIES: SPECIFY YEAR AND TYPE: _____

SIGNIFICANT FAMILY ILLNESSES OR

PROBLEMS: _____

CURRENT

MEDICATIONS: _____

Do you have insurance if so, list company with policy number. _____

II. PHYSICAL EXAMINATION: To be completed by physician
(please indicate any significant findings and give recommendations as desired)

Skin _____	Abdomen _____
Eyes _____	Hernia _____
Ears _____	Extremities _____
Nose and Throat _____	Genito-Urinary _____
Mouth _____	Nutritional Status _____
Glands _____	Vision(if done) R _____ L _____
Heart _____	Hearing(if done) R _____ L _____
Lungs _____	

III. SPECIFIC MEDICAL RECOMMENDATIONS TO SCHOOL FOR ACADEMIC AND ACTIVITY PROGRAM

PHYSICIAN'S SIGNATURE _____ DATE _____
ADDRESS _____