STUDENT'S HEALTH EXAM FORM

CHILD'S NAME_____SCHOOL_____

BIRTH DATE_____SEX _____GRADE_____

ADDRESS_____
Street Address City Zip Code

PARENT'S NAME_____TELEPHONE_____

MEDICAL HISTORY	RECORD OF ILLNESSES	YEAR
Physical Handicaps	Frequent Ear Infections	
	Mumps	
Rheumatic Fever	German Measles, PROVED BY BLOOD TEST	
	Regular Measles	
Heart/Restriction on activities	Chicken Pox	
	Whooping Cough	
	Other Illnesses	
Seizures	Operations	
Allergies		
Asthma	Descriptions of Injuries	
Allergies		

PARENTS PLEASE FILL OUT TO THIS LINE

HEALTH CONDITIONS

Date	Date
Hyperkinesis	Seizure disorder
Heart Disease	Diabetes
Allergies	Other
Asthma	

Significant Health History_____

Significant Physical Findings and Recommendations_____

Physical Education Activity Recommendations:

_____Full Activity

_____Full activity without competitive sports

_____Full activity under close supervision

_____Limited activity, specify: _____

_____

_____

On Medication? _____

Date of Exam: _____

_____
Physician's Signature

_____
Address