HEALTH HISTORY

[To be completed by parent or guardian]

I. GENERAL INFORMATION

Child's Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City of Birth: _____

Father's Name: _____ Telephone: _____

Mother's Name: _____ Physician: _____

II. DISEASE & ILLNESS HISTORY

Disease/Illness	Date	Disease/Illness	Date	Disease/Illness	Date
Arthritis		Earaches		Pneumonia	
Asthma/Allergies		Epilepsy		Rheumatic Fever	
Cancer		Fractures		Scoliosis	
Cerebral Palsy		Heart Problem		Skin Condition	
Chicken Pox		Measles		Tuberculosis	
Convulsions		Migraines		Whopping Cough	
Cystic Fibrosis		Mumps			
Diabetes		Muscular Dystrophy			

Injuries (types and dates): _____

_____

Hospitalizations (reasons and dates): _____

_____

Operations (specify): _____

Allergies: _____

Vision/Hearing Information: Glasses _____ Contacts _____ Color Blind _____ Hearing Deficit _____

Please list any medications taken at home: _____

Please list any medications to be taken at school: _____

(A permit to dispense medication must be filled out by the doctor and parent and kept on file at school).

III. TUBERCULOSIS TEST

Type: _____ Date: _____ Result: _____ By: _____

IV. EMOTIONAL AND BEHAVIOR HISTORY (note special problems and age of occurrence)

_____

_____

V. MEDICAL EXAMINATION (Medical examination form on reverse side should be completed by your physician.)

Date: _____ Signature of Parent: _____

MEDICAL EXAMINATION REPORT – TO BE COMPLETED BY PHYSICIAN

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

General appearance, nutritional state, vitality: _____

Skin (color, condition, eruptions?): _____

Head (size, shape, symmetry): _____

Ears (right) _____ (left) _____ Hearing (right) _____ (left) _____

Eyes (right) _____ (left) _____ Vision (right) _____ (left) _____

Nose: _____ Throat: _____

Neck (lymph nodes and thyroid): _____

Chest: _____ Heart: _____

Lungs: _____ Genitalia: _____

Abdomen (hernia?): _____

Posture and extremities (including skeletal abnormalities): _____

Neurological: _____

Comments on Emotional Behavior: _____

Speech difficulty: _____

Other (including lab reports): _____

Is this child capable of carrying a full program of schoolwork including gymnastics and athletics?

Yes _____ No _____ Recommended restrictions: _____

MEDICAL CERT. OF IMMUNIZATION

Disease	1st Date	2nd Date	3rd Date	4th Date	5th Date
DTaP/DTP/DT Diphtheria, Tetanus, Pertussis					
Polio					
MMR (Measles-Mumps-Rubella)					
Rubella (German measles)					
Rubeola (Regular Measles)					
Mumps					
Varicella (Chicken Pox)					
Hepatitis B					
TB Skin Test					
Hib (Preschool) Haemophilus Influenza Type B					

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				**Reason not completed (Check which applies)**	
Assessments/Screenings	Completed Please circle one		Date Completed	Health Professional Decision	Examples: religious conviction, insurance coverage, other
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

Date: _____ Physician's Signature: _____

Address: _____