



Health Form Part I (Medical History)

Completed and Signed by Parent/Guardian

Student's Last Name	First Name	Middle	Date of Birth	Grade	RESIDENT	DAY	
Please answer Yes or No. Give date. Has student ever had or does he have:							
	YES	NO	DATE		YES	NO	DATE
Allergies, food, drug, other				Liver disease			
Anemia/bleeding disorders				Meningitis			
Other blood disease				Migraine headaches			
Arthritis				Nervous or mental disease			
Asthma				Pneumonia			
Chicken Pox				Poliomyelitis			
Diabetes				Rheumatic fever			
Diphtheria				Sinus			
Ear Problem/loss of hearing				Skin disease			
Epilepsy				Thyroid trouble			
Hay Fever				Tuberculosis			
Heart Conditions				Ulcer, Stomach or duodenal			
Hernia				Vertigo (dizziness) or fainting spells			
Kidney Disease				Other			
IF YES, OR ANY DISEASE (except usual childhood diseases), GIVE DETAILS: _____							
CIRCLE EACH ITEM 'YES' OR 'NO'							
1. HAS YOUR SON EVER HAD A HEAD INJURY, HEAT STROKE, HEAT EXHAUSTION OR HEAT CRAMPS?				YES	or	NO	
2. HAS YOUR SON EVERY BEEN UNABLE TO TAKE PHYSICAL EDUCATION OR PARTICIPATE IN SPORTS BECAUSE OF HIS HEALTH?				YES	or	NO	
3. HAS YOUR SON EVER HAD A SERIOUS INJURY OR OPERATION?				YES	or	NO	
4. HAS YOUR SON USED THE SERVICES OF A PSYCHOLOGIST, PSYCHIATRIST OR OTHER MENTAL HEALTH PERSONNEL OR CLINIC?				YES	or	NO	
IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____							
<input type="checkbox"/> PLEASE LIST DRUGS TO WHICH YOUR SON IS ALLERGIC: _____							
<input type="checkbox"/> DATE OF LAST TETANUS IMMUNIZATION: _____							
Parent's Signature X					Date		

Health Form Part II (Physical)

Completed and Signed by Physician

This record is filed with our nurse in the school dispensary.

Height:	Weight:	Pulse:	B/P:	Vision: right 20/	left 20/
		norm	abnorm	Comments	
Heart					
Lungs					
Back & Extremities					
Throat					
Lymph glands					
Thyroid					
Hernia					
Hearing					
Abdomen					
Neurological					
Urinalysis: Sp Gr	Alb	Sugar	Micor		
The following is recommended:					
Eye refraction:			Audiometer test:		
Recommended Medicines:			Special Care/Comments:		
I have conducted a limited physical examination of the student named above and within the scope of this examination have found no obvious reason that this student may not participate in the school athletic program.					
Physician's Signature X				Date X	

