SCHOOL CITY OF HAMMOND
Department of Health Services

Medical History/Physical Form

Name____Birthdate______________________________

Parent or Guardian ____

Disease	Date	Disease	Date
Chicken Pox	___________________	Whooping Cough	________________________
German Measles	___________________	Measles	________________________
Mumps	___________________	Other	________________________

Mother's health during pregnancy:

Was there illness or complication at birth? Explain _________________________________ Date____________

Has your child had a serious accident? Explain ____ Date____________

Has your child ever been in the hospital or had an operation? Explain ____
____ Date____________

Does your child have:

Allergy (specify) ____

Seizures ____

Bronchitis or asthma ____

Diabetes ____

Other ____

Does anyone in the family have:

Allergy (specify) ____

Seizures ____

Bronchitis or asthma ____

Diabetes ____

Tuberculosis ____

Other ____

DENTAL EXAMINATION

I have examined the teeth of ____ Date_________________

Dental correction necessary____

Dentist's corrections completed____

Mouth in good condition____

Dentist Signature________________________________

Print Name______________________________________

Address____

Name____

**History of Tuberculosis ☐ NO ☐ YES Test if Needed: Date_____________Result______________

Sickle Cell Anemia Test ______________________________ Lead Poisoning Test_________________________________

Physical Examination and Immunizations

- Diphtheria, Tetanus & Pertussis 1__________ 2__________ 3__________ 4__________ 5__________
- Polio 1__________ 2__________ 3__________ 4__________
- TDAP (Grade 6-12) 1__________
- MMR 1__________ 2__________
- Menactra 1__________ 2__________
- Hepatitis B 1__________ 2__________ 3__________
- Varicella 1__________ 2__________
- Hepatitis A 1__________ 2__________
- HPV (recommended) 1__________ 2__________ 3__________

(Please check if normal or abnormal; if abnormal, describe below)

	Normal	Abnormal
Physical Development		
Nutritional Development		
Skin		
Hair and Scalp		
Eyes (except Vision)		
Ears (except Hearing)		
Nose		
Throat		

	Normal	Abnormal
Lungs		
Heart		
Abdomen		
Extremities		
Orthopedic		
Scoliosis		
Other Defects		
Not Listed		

Is your child under medical treatment? ☐ NO ☐ YES

If yes, state reason ____

Treatment____

Physical Fitness Evaluation

Please check on of these recommendations:

- ☐ I recommend the regular school program (Physical Education including running, basketball, tennis, etc.)
- ☐ I recommend modified activity (Specify degree and reason [Physical Education including ping-pong, throwing, etc])
- ☐ I recommend exclusion from physical education. **Reason must be given.**

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Recommendations for modified activity or exclusion are effective for the current school year only, unless specified below. Comments and recommendations.

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Date _________________________ Physician Signature____

Print name and address ____

**required for high school entrance for high risk patients