

# MEDICAL HISTORY

Revised 6/09



To be completed and signed by child's physician:

Child's Name:	Date of Birth:
Parent's Name:	Date of Exam:

Indicate any known health problems.  
Give dates and explain:

Indicate if the student has had the following diseases:

Asthma	Chicken pox:				
Allergies	Measles (10 day)				
Diabetes	Rubella (3 day)				
Heart problems	Mumps				
Kidney disease	Strep infection				
Seizure disorder	Whooping cough				
Ear problem/hearing disorder	Hepatitis				
Eye problem/glasses	Meningitis				
Operations, fractures, head injuries	Other				
Medications (even if given at home)					
TB contact in the family	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Yes</td> <td style="width: 25%;">No</td> <td style="width: 25%;">Skin test</td> <td style="width: 25%;">X-ray</td> </tr> </table>	Yes	No	Skin test	X-ray
Yes	No	Skin test	X-ray		

### Required Immunizations (enter month, day, and year)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP					
OPV					
HIB					
MMR					
Hepatitis B					
Varicella					
TB					

List any handicap or special health condition of the child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate any limitations or modifications of the child's participation in daily school related activities or any special treatments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This is to certify that I have examined this child and have found that:

1. This child has had the immunizations require by Section 3313.671 of the Revised Code for admission to school, or; has had the immunizations required by the state department of health, or is exempted from these requirements for medical reasons.
2. Based upon medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition to attend school.

Name of Physician (please print)	Telephone Number
Street Address	
City, State, and Zip Code	
Physician's Signature	Date of Physician's Signature