SCHOOL CITY OF HAMMOND
Department of Health Services

Medical History

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.**

____

____

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

____

____

Date _________________________ Physician Signature ____

Print name and address ____

**required for high school entrance for high risk patients