



M E D I C A L H I S T O R Y

Name _____ Age _____ Gender _____
Last First Middle (Full)

Date of Birth: _____ Place of Birth: _____
(Month) (Day) (Year)

The following information is accurate to the best of my knowledge. I am aware that inaccuracies or omissions may jeopardize my child's health.

Signature over Printed Name of Parent/Guardian

Date

Home Address _____

Phone Number _____

Mobile _____

PARENT or LEGAL GUARDIAN

Name _____

Home Address _____

Phone Number _____

Mobile _____

Do you have a family doctor?

Yes No

Name _____

Home Address _____

Phone Number _____

Mobile _____

SIGNIFICANT HISTORY:

Allergy (Type) _____

Epilepsy _____

Rheumatic Fever _____

Tuberculosis _____

Surgery _____

Communicable Diseases (Check Only)

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps
<input type="checkbox"/> Measles (Rubeola)	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Typhoid	<input type="checkbox"/> Hi Fever

I attest to the veracity of the information stated herewith

Examining Physician: _____ M.D.

Date of Examination: _____

** Please attach photocopy of most recently updated vaccination schedule issued by your child's doctor.