Physical Form- TO BE COMPLETED BY PHYSICIAN

Child's Name: ______________________________________ Birth Date: ___________________
Past Illnesses- Check those the child has had and give approximate dates:

| Chicken Pox: | Rubella: | Hay Fever: |
|---|---|---|
| Rheumatic Fever: | Asthma: | Epilepsy: |
| Diabetes: | Mumps: | Polio: |
| Whooping Cough: | Ear Infections: | Other: |

Please give location of any pigmented lesions, birth marks, or other permanent scarring:

_______________________________________________________________________________

Surgery/Accident/Illnesses/Chronic Heath Problems:

_______________________________________________________________________________

List any physical conditions requiring our special attention and/or restrictions:

_______________________________________________________________________________

List any dietary need/restrictions:

_______________________________________________________________________________

Medications Prescribed:

_______________________________________________________________________________

Allergies: _____________________________ Vision: _________________________________
Hearing: ______________________________

Current Health Status: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Examination Date:___________________
Physician's Signature: ____________________________________________ Date: ________

**Please Print**

Name of Health Care Professional: ______________________________________________

Address: ____________________________________________________

City: ______________________________________ Zip: __________

Phone: __________________________Fax: _________________________