Medical Exam Form

Child's Full Name_______________________________ ☐ Male ☐ Female DOB _________________ Age (as of 9/1)__________

Father's Name: ____ Mother's Name: _______________________________________

Home Address: _______________________________City: __________________State:_________Zip:___________________

Home Phone: (____)_____________________ Work Phone: (___)_____________________ Cell: (___)_____________________

Child's Doctor: ____ Phone (_________)_____________________________

Address: ____

A medical exam form is required by October 1 or 30 days after a student starts HIH.
Please list date of scheduled appointment if not completed: ______________________

To Be Filled Out By Physician or Health Care Source:

1. Date of last physical examination: ____
2. How long have you been seeing this child: ____
3. Does this child have any allergies (including allergies to medicine)? Please list: ________________________________
4. Is the child taking any medications?_____________If so what? ____
5. Is a modified diet necessary? Please describe: ____
   ____
6. Is any condition present that might result in an emergency? Please describe: ______________________________________
   ____
7. Does the child have any communicable or infectious disease that would affect his/her ability to participate in a group program? ______
8. If yes to Question 7, please explain in detail: ____
   ____
9. Does the child have chronic illness or allergies that require special instructions? ______ If so, please contact the HIH Health Consultant for follow-up forms.
10. What is the status of the child's vision? ____
11. What is the status of the child's hearing? ____
12. What is the status of the child's speech? ____
    ____
13. Please list important health problems: ____
    ____
14. Please list other health considerations that would be helpful for the Hand In Hand staff to know: _____________________________
    ____

Statement of Accuracy: I certify that the above information is accurate and answered to the best of my knowledge:

Signature of Physician or Public Clinic: ____Date: ____________________________