



# 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: \_\_\_\_\_