

McGUFFEY FOUNDATION SCHOOL
HEALTH INFORMATION FORM
(Return by September 15)

GENERAL INFORMATION

Today's Date ____/____/____

Student's Name _____ Male ____ Female ____ Date of Birth ____/____/____

Home Address _____ Phone _____
Street City State Zip

Parent1's Name _____ Phone _____ Cell Phone _____

Home Address _____ Phone _____
Street City State Zip

Parent2's Name _____ Phone _____ Cell Phone _____

Home Address _____ Phone _____
Street City State Zip

(Give dates if your child has had the disease)

Chicken Pox ____/____

Whooping Cough ____/____

Measles ____/____

Mumps ____/____

Diphtheria ____/____

Tuberculosis ____/____

Poliomyetis ____/____

Rheumatic Fever ____/____

Diabetes ____/____

German Measles (Rubella) ____/____

Epilepsy or convulsions? _____

Allergies, Eczema, Hay Fever, Asthma? _____

Frequent sore throats? _____ Infected Ears? _____

Headaches? _____ Injuries? _____

Hospitalizations (reasons, dates)? _____

Operations (specify)? _____

Other Illness? _____

EMOTIONAL AND BEHAVIOR HISTORY (note special problems and age of occurrence)

MEDICAL EXAMINATION: your physician should complete medical Examination Form on reverse side.

Signature of Parent _____ Date ____/____/____

MEDICAL EXAMINATION REPORT - BY PHYSICIAN

Name _____ Birth Date ____/____/____ Height _____ Weight _____
 Last First Middle

General appearance, nutritional state, and vitality: _____

Skin (color, condition, eruptions?) _____

Head (size, shape, symmetry?) _____

Ears (right) _____ (left) _____ Hearing (right) _____ (left) _____

Eyes (right) _____ (left) _____ Vision (right) _____ (left) _____

Nose _____

Throat _____

Neck (lymph nodes and thyroid) _____

Chest _____

Heart _____

Lungs _____

Abdomen _____

Genitalia _____

Posture & extremities (including skeletal abnormalities) _____

Neurological _____

Comments on Emotional Behavior _____

Speech Difficulty _____

Other, including lab reports _____

Is this child capable of carrying a full program of schoolwork including gymnastics and athletics? _____ Yes _____ No

Recommended restrictions: _____

MEDICAL CERTIFICATION OF IMMUNIZATION

(May be completed by parent/guardian)

Butler Co. Health Dept. requires doctor's confirmation of occurrence of communicable disease.

DISEASE		1st Date	2nd Date	3rd Date	4th Date	5th Date
Diphtheria		_____	_____	_____	_____	_____
Whooping Cough		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Salk	P	_____	_____	_____	_____	_____
Trivalent Oral (TOPV)	O L I O	_____	_____	_____	_____	_____
MR (Combined Measles)		_____	_____	_____	_____	_____
MMR (Measles- Mumps-Rubella)		_____	_____	_____	_____	_____
Rubella (German Measles)		_____	_____	_____	_____	_____
Rubeola (Regular Measles)		_____	_____	_____	_____	_____
Mumps		_____	_____	_____	_____	_____
Varicella (Chicken Pox)		_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____
HIBS		_____	_____	_____	_____	_____

TB Skin Test Type _____ Date _____ Result _____ By _____

Date ____/____/____ Physician's Signature _____ Address _____