



Gingerbread Little Varsity

fax number

Medical Form

Name of child----- Age----- Birth date-----
Name of parent-----
Address of parent-----

MEDICAL HISTORY

1. Previous hospitalization? Yes----- No----- If so what? -----
2. Is child allergic to anything? Yes----- No----- If so what? -----
3. Any previous diseases or illnesses? Yes----- No----- If so what? -----
4. Any operations? Yes----- No----- If so what? -----
5. Any physical handicaps? Yes----- No----- If so what? -----
6. Is child under the care of a doctor? Yes----- No----- If so what? -----
7. Any history of mental retardation? Yes----- No-----
8. Any history of convulsions? Yes----- No-----
9. Any history of diabetes in family? Yes----- No-----
10. Any history of heart trouble? Yes----- No-----
11. Any history of asthma? Yes----- No-----

Parent signature date

PHYSICAL EXAMINATION (Must be completed and signed by examining physician)

Weight----- Height----- Heart----- Chest----- Throat----- Neck----- Abdomen-----
Gu----- Ext.----- Neurological System-----
Teeth----- Skin----- Head----- Eyes----- Ears-----
Results of Tuberculin Test, if given-----

Type Results

Should activities be limited? -----
Recommendations: -----

IMMUNIZATION HISTORY (enter date of each immunization received)

DTP 1. ----- 2. ----- 3. ----- 4. ----- 5. -----
Polio 1. ----- 2. ----- 3. ----- 4. ----- 5. -----
MMR 1. ----- 2. ----- Varcella 1. ----- Hep B 1. -----
Hib 1. ----- 2. ----- 3. ----- 4. -----

Physician signature date

Address and phone number