Blessed be God!

VMCHS MEDICAL HISTORY/EXAMINATION

Full Name	
Date of Birth	Grade
Physician	Date of exam
Physician's Signature	

SIGNIFICANT HEALTH HISTORY	YES	NO	YEAR		YES	NO	YEAR
Asthma				Hepatitis			
Birth problem				Mononucleosis			
Bone, Joint, Muscle problems				Mumps			
Chickenpox				Rheumatic Fever			
Diabetes				Scarlet Fever			
Frequent colds/allergies				Seizures/Epilepsy			
Frequent ear infections				Speech problems			
Heart Disease				Typhoid Fever			
Scoliosis				Thyroid			

ALLERGIES	YES	NO	COMMENTS
Medications			
Bee sting			
Food			
Other			

Student **does***________ **does not**________ (Initial) present significant condition(s) that impede(s) the participation in sports and/or any physical activities

PHYSICAL/PSYCHOLOGICAL CONDITION AS PER EXAMINATION - *Please type or print legibly*

KNOWN EYE PROBLEMS	YES	NO
Glasses		
Contacts		
Preferencial seating		
Date of last exam		

KNOWN EAR PROBLEMS	YES	NO
Hearing Aid		
Preferencial seating		
Date of last exam		

* If yes, please provide explanation

***COPY OF IMMUNIZATION RECORD MUST BE PRESENTED ALONG WITH THIS FORM