



Eleanor Kolitz Academy

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HEALTH AND MEDICAL RECORD

(To be completed by child's physician)

Child's Name _____ Gender _____ Birth date _____ Parent/Guardian _____

PHYSICAL EXAMINATION

Date of Examination _____ Height _____ Weight _____ B.P. _____

Eyes: Without glasses: R 20/____ L 20/____ With Glasses: R 20/____ L 20/____

Ears: Hearing R _____ L _____

Code: N Normal A Abnormal

Nose _____ Throat _____ Teeth _____ Hernia _____

Heart _____ Lungs _____ Abdomen _____ Genitalia _____

Skin _____ Musculoskeletal _____ Urinalysis _____ HGB _____

Other Observations: _____

MEDICAL/SURGICAL HISTORY (please check and **give dates** and details where applicable);

Allergies (please specify): Food: _____ **Childhood Diseases**

Medication: _____ Chicken pox: _____

Environmental: _____ Measles: _____

Operations and Serious Injury _____ German Measles: _____

Accidents: _____ Mumps: _____

Blood Transfusions: _____ Chronic illnesses: _____

Please check all that apply:

Asthma: _____ Ear Infections: _____ Frequent headaches: _____ Immune Deficient Disorders: _____

Diabetes: _____ Eating Disorders: _____ Frequent stomachaches: _____ Rheumatic Fever: _____

Has a social worker, psychologist, or psychiatrist ever seen this child, if so, please give a brief description on the back of this page.

IMMUNIZATIONS:

IMMUNIZATION	1st dose	2nd dose	3rd dose	Booster	Booster
DPT-DT					
Polio					
MMR					
Pro Hib					
HBV (Hep. B)					
Hep A					

TB test _____ If the test result is positive, a physician's statement is necessary.

LIMITATIONS, SPECIAL NEEDS OR CONDITIONS:

Please specify any special needs or conditions which may require professional consultation by the school or the parents in order to insure adequate care for this child. Please also specify any limitation that should be placed on this child's activities. Use reverse side if necessary.

STATEMENT OF EXAMINATION:

This child was examined by me and found to be free of all contagious and transmissible diseases and is physically able, with the exceptions noted herein, to participate in the school program.

Physician's Signature

Address

Date