			E	Birth D	ate:	Gender:	M	F
Grade:		School:			Sport:			
					Home Phone:			
					Daytime Phone			
					Daytime Phone			
		12		1.0				
_	•	•			r parent can be reache	•		
Name:		Rela	tion:		Daytime Pho	ne:		_
Medical I	History	y						
			Yes	No			Yes	No
Any significant past injuries					Hospitalizations or su	ırgeries		
Allergies, asthma, or wheezing					Seizures			
	Contact lenses or glasses				Head injuries or cond	ussions		
	glasses							
Contact lenses or Currently on med		dications			Bone or joint injuries			
Contact lenses or Currently on med Chronic illness		dications			Current on all vaccina			
Contact lenses or Currently on med	ication/med							
Contact lenses or Currently on med Chronic illness Allergies	ication/med				Current on all vaccina			
Contact lenses or Currently on med Chronic illness Allergies Comments:	ication/med				Current on all vaccina			
Contact lenses or Currently on med Chronic illness Allergies Comments:	Exam			Neu	Current on all vaccina Other:	ations		
Contact lenses or Currently on med Chronic illness Allergies Comments:	Exam			_	Current on all vaccina Other: Result	ations		
Contact lenses or Currently on med Chronic illness Allergies Comments: Physical Ears	Exam			Ger	Current on all vaccina Other: Result	ations		
Contact lenses or Currently on med Chronic illness Allergies Comments: Physical Ears Nose Throat Eyes	Exam			Ger Gas Spir	Current on all vaccina Other: Result prological pito-urinary trointestinal mal	ations		
Contact lenses or Currently on med Chronic illness Allergies Comments: Physical Ears Nose Throat Eyes Skin	Exam			Ger Gas Spir Me	Current on all vaccina Other: Result Irological iito-urinary trointestinal nal ntal Health	ations		
Contact lenses or Currently on med Chronic illness Allergies Comments:	Exam			Ger Gas Spir Me Car	Current on all vaccina Other: Result prological pito-urinary trointestinal mal	ations		