

This form must be completed by a physician and on file at Bridges within 4 weeks of enrollment in our program.



51960 Gumwood Road
Granger, IN 46530
Phone/Fax 574-277-4525

MEDICAL HISTORY FORM

CHILD: _____ DOB: ____/____/____

ADDRESS: _____

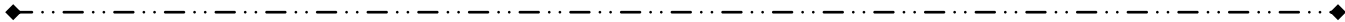
PHONE: _____ PARENT (OR LEGAL GUARDIAN): _____

MEDICAL HISTORY

| | <u>MONTH/YEAR</u> | | <u>EXPLAIN IF PRESENT</u> |
|------------------------|-------------------|----------------------------|---------------------------|
| MEASLES | _____ | ALLERGIES | _____ |
| RUBELLA (GER. MEASLES) | _____ | | _____ |
| CHICKENPOX | _____ | HANDICAPPING CONDITIONS | _____ |
| MUMPS | _____ | | _____ |
| WHOPPING COUGH | _____ | | _____ |
| OTHER _____ | _____ | | _____ |

PARENT / LEGAL
GUARDIAN
INITIALS

NO INDIVIDUAL AND/OR INSTITUTION SHALL HAVE ACCESS TO THIS MEDICAL INFORMATION WITHOUT THE WRITTEN CONSENT OF A PARENT OR LEGAL GUARDIAN.



THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A PHYSICIAN

PHYSICAL EXAMINATION

DATE OF EXAM: ____/____/____

AGE OF CHILD: _____

SKIN _____

HEART _____

LYMPH NODES _____

LUNGS _____

EYES _____

ABDOMEN _____

NASOPHARYNX _____

GENITALIA _____

TEETH & MOUTH _____

SKELETON _____

OTHER _____

NOTE ANY UNUSUAL FINDINGS _____

DOES THIS CHILD HAVE ANY HEALTH CONDITION THAT WOULD BE HAZARDOUS EITHER TO HIM/HERSELF OR TO OTHER CHILDREN IN A GROUP SETTING AS A RESULT OF PARTICIPATION IN NORMAL ACTIVITIES?

NO

YES

IF YES, WHAT MODIFICATION OF NORMAL ACTIVITIES WOULD BE NECESSARY TO PROTECT THE CHILD AND HIS/HER CLASSMATES?

HAVE YOU PRESCRIBED ANY MEDICATIONS OR SPECIAL ROUTINES THAT SHOULD BE INCLUDED IN THE SCHOOL'S PLANS FOR THIS CHILD'S ACTIVITIES?

NO

YES

IF YES, PLEASE DESCRIBE.

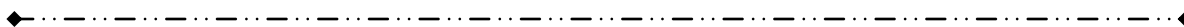
***A COMPLETE AND UP TO DATE IMMUNIZATION
RECORD MUST ACCOMPANY THIS FORM***

FORM COMPLETED BY: _____

PLEASE PRINT

OFFICE PHONE NUMBER: _____

PHYSICIAN'S SIGNATURE: _____



ADDITIONAL NOTES AND INSTRUCTIONS: _____
