VICKSBURG COMMUNITY SCHOOLS

Medical History Form

This form is to be completed by parent and brought to pre-school clinic or taken to your own physician to be completed. Please take all records of immunizations with you.

SCHOOL: _____ DATE: _____

CHILD'S NAME: _____ BIRTHDATE: _____

PARENT'S NAMES: _____ PHONE: _____

ADDRESS: _____

FAMILY DOCTOR: _____ FAMILY DENTIST: _____

IMMUNIZATION DATES: Please furnish a copy of your child's **immunization record** when submitting this form to the school.

Has your child had any of the following diseases?

	Yes	No		Yes	No
Rheumatic Fever	___	___	Chicken Pox	___	___
Meningitis	___	___	Scarlet Fever	___	___
Measles	___	___	Mumps	___	___
Ear Infections	___	___	Other	___	___

Does your child have any of the following conditions?

	Yes	No	Comments
Vision Problems	___	___	_____
Hearing Difficulty	___	___	_____
Brain Damage/Head Injury	___	___	_____
Speech Problem	___	___	_____
Emotional Problems	___	___	_____
Heart Condition	___	___	_____
Seizures of Any Kind	___	___	_____
Fainting Spells	___	___	_____
Allergies	___	___	_____
Diabetes	___	___	_____
Physical Handicaps	___	___	_____
Other	___	___	_____

HAS YOUR CHILD EVER HAD ANY OPERATIONS? If yes, please list: _____

_____

IS YOUR CHILD TAKING MEDICATION? Kind _____

Will it be taken at School? _____

VICKSBURG COMMUNITY SCHOOLS

Pre-School Medical Examination Form

This form to be used by your own physician, well child clinic, or at our pre-school clinic

CHILD'S NAME: _____ SCHOOL: _____

DATE OF EXAMINATION: _____

Code: Satisfactory - 0 Unsatisfactory - Name Defect

HEIGHT _____ WEIGHT _____

POSTURE _____ EYES _____

NUTRITION _____ EARS _____

SKIN _____ NOSE, THROAT, TONSILS _____

FEET _____ GLANDS _____

ABDOMEN _____ HEART _____

HERNIA _____ LUNGS _____

GENITALS _____ OTHER _____

RECOMMENDATIONS

It is recommended that the above child be referred for further examination in regard to the following:

BEHAVIOR _____

MEDICAL CARE _____

SPEECH REFERRAL _____

_____

Examining Physician

_____

Date

VISION TEST (By Whom) _____ **HEARING TEST** (By Whom) _____

DATE COMPLETED _____ RESULTS _____ DATE COMPLETED (By Whom) _____ RESULTS_____

DENTAL EXAM (optional) (By Whom) _____

DATE COMPLETED _____ RESULTS _____