

# מב"מ Maimonides School

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## PHYSICIAN'S HEALTH FORM (TO BE COMPLETED BY PHYSICIAN ONLY)

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_  
Street/Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ **DATE of Last Complete Examination:** \_\_\_\_\_

### IMMUNIZATIONS (REQUIRED BY STATE LAW) — List date.

DPT	1 _____	2 _____	3 _____	4 _____	5 _____
Td Booster	1 _____	(required for Grade 7 or >5 years since last dose)			
Polio	1 _____	2 _____	3 _____	4 _____	
MMR	1 _____	2 _____			
HIB	1 _____	2 _____	3 _____	4 _____	
Tuberculin Test	1 _____	2 _____	3 _____	4 _____	
Hepatitis B	1 _____	2 _____	3 _____		
Varicella Vaccine	1 _____	2 _____	(required if no history of chickenpox disease)		
	(one dose <13 years)	(two doses >13 years)			
Chickenpox Disease	_____				
Lead Screen	_____	(required for kindergarten)			

### HISTORY (Including major medical, developmental or allergic problems)

<b>Health Examination:</b>	Height _____	Weight _____
Blood Pressure _____	Resting Pulse _____	Urinalysis _____
Posture Exam _____	Heart _____	Hgb Test _____
Ears _____	Lungs _____	Hernia _____
Eyes _____	Skin _____	Genitalia _____
Nose _____	Throat _____	Abdomen _____

Current medical problems, recent injuries, operations or chronic conditions: \_\_\_\_\_

Current medications: \_\_\_\_\_

Please list any restrictions and explain: \_\_\_\_\_

### DOCTOR PERMISSION

The child is able to participate in school activities, including competitive sports and physical education, unless otherwise noted above.

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Name (print): \_\_\_\_\_ Telephone: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_