MEDICAL QUESTIONNAIRE

To be filled out by your family physician

Name:_____ Date of birth:_____

Home address:_____

Phone number:_____

Weight_____ Height_____
Skin_____ Ears_____ Hearing_____ Tonsils_____
Heart_____ Lungs_____ Feet_____ Appendix_____
Hernia_____ Liver_____ Glands_____ Blood Pressure____
Urine Analysis_____

Tendencies to : Bronchitis_____ Allergies_____
Medications_____

Has the applicant had any of the following? (Give date)

Appendicitis_____ Otitis Media_____
Bronchitis_____ Pleurisy_____
Chicken Pox_____ Pneumonia_____
Chorea_____ Poliomyelitis_____
Epilepsy_____ Ringworm_____
German Measles_____ Rheumatic Fever_____
Hernia_____ Scarlet Fever_____
Influenza_____ Sinus Infection_____
Measles_____ Tonsilitis_____
Mumps_____ Whooping Cough_____
Nephritis_____ Allergies_____

Any allergies to medication?_____

Has the applicant been exposed to any contagious diseases within the past six weeks?_____
If so, what?_____

Polio Vaccinations_____ Salk_____ Sabin_____Tetanus_____

Is the applicant under any treatment or medication at the present time?_____

Has the applicant ever been diagnosed, counselled, or treated for a learning or reading disability? Give details._____.

Has the applicant received psychological/ psychiatric counselling? YES/ NO . If yes, print name and address of psychologist/ psychiatrist._____

Any recommendations or precautions with respect to diet, swimming, diving, hiking, or any other strenuous activities?_____

General remarks_____

_____

Date of examination_____ Signature_____

Address_____

Tel. #_____

License_____

Parental Authorization:
I do hereby authorize the Dean of the Yeshiva or the Administrator to authorize emergency medical treatment on the advice of a physician for my child.

Signature of Parent_____