MEDICAL FORM

Children Learn What They Live.

*Valid one year

Year: _____

This report is to be completed only by an authorized medical professional. Attach all corresponding reports.

GENERAL DATA

Last Name: _____ First Name: _____

Grade: _____ Age: _____ Sex: ◯ Male ◯ Female

Height: _____ cm Weight: _____ kg Blood Type: _____

Heart Rate: _____ Blood Pressure: _____

GENERAL HEALTH

Vision	◯ Good	◯ Recommendation	_____
Hearing	◯ Good	◯ Recommendation	_____
Breathing	◯ Good	◯ Recommendation	_____
Lungs	◯ Good	◯ Recommendation	_____

MEDICATION

Is any special medicine taken? Name: _____ Dosage: _____

What kind of medicine is taken for pain? Name: _____ Dosage: _____

What kind of medicine is taken for fever? Name: _____ Dosage: _____

ALLERGIES

Allergies: _____ Medicine: _____ Dosage: _____

Allergies: _____ Medicine: _____ Dosage: _____

FAMILY HISTORY

Indicate any family illness:

IMPEDIMENTS

Do any symptoms or disorders exist that limit or impede regular assistance to class?

Do any symptoms or disorders exist that limit or impede participation in sports?

I hereby certify that _____, of _____ years of age, does not show any of the pediatric physical examination, health impairments at the moment, to participate in physical fitness, education, and sports, according to student age and level of physical fitness, under the supervision of the teacher, unless a pathology exists and is currently non-detectable through physical examination.

PROFESSIONAL MEDICAL DATA

Physician name: _____ Signature: _____

Telephone: _____

Date: _____ Stamp Lic # _____

EMERGENCY CONTACT INFORMATION

Name of parents or guardian: _____

Cellphone: _____

If unable to contact parents or guardians, please call _____ at _____

Refer to this hospital: _____

Does the student have a medical insurance? ◯ Yes ◯ No Company? _____

VACCINE SERIES

Provide a copy of immunization record and COVID 19 vaccination if aplicable.