

# FOX



## LEARNING CENTER

**PLEASE RETURN COMPLETED MEDICAL FORM TO :**  
**Fox Learning Center, 1329 Route #38, Hainesport, N.J. 08036 , FAX (856) 755-1633**

**Child's Name** \_\_\_\_\_

**Date of Examination** \_\_\_\_\_

**Part 1: History (to be completed by parent or medical staff) Has the child had any of the following conditions? What year?**

Measles _____	Epilepsy _____	Poliomyelitis _____	Diabetes _____
Chicken Pox _____	Heart Disease _____	Pneumonia _____	Mumps _____
Hernia _____	Diphtheria _____	Otitis media _____	Convulsions _____
Rheumatic fever _____	Scarlet fever _____	Whooping Cough _____	Any allergies _____

**Part 2: Results of Examination (to be completed by physician)**

Throat _____	Nose _____	Neck _____	Spine _____	Lungs _____	Reflexes _____
Heart _____	Pulse _____	Abdomen _____	Genitalia _____	Extremities _____	Lymph glands _____
Rectum _____	Skin _____	Thorax _____	Teeth & Mouth _____	Scalp _____	
Eyes & Vision _____	Ears & Hearing _____	Other _____	Height _____	Weight _____	

**Please indicate any conditions which might affect this child's performance at school or any special condition of which the staff should be aware (medical treatments, special requirements as to diet, rest, allergies, physical handicaps, or avoidance of certain activities and other care).**

\_\_\_\_\_

The above named child has been given a routine medical examination and has been found to be free of infectious or contagious diseases.

Signature of physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Address of physician \_\_\_\_\_