



MEDICAL HISTORY AND PHYSICAL EXAMINATION REPORT

မိဘအုပ်ထိန်းသူများမှ Part (I) တွင်ဖော်ပြထားသော အချက်အလက်များကို ပြည့်စုံစွာဖြည့်စွက်ပေးပါရန်နှင့် Part (II) ပါ အချက်အလက်များကို ပြနေကျကလေးဆရာဝန် (သို့) မိသားစုဆရာဝန်မှ ဖြည့်စွက်ရန်။
 မှတ်ချက်။ ။ အချက်အလက်များ ပြည့်စုံမှန်ကန်မှုမရှိပါက ကျောင်းအပ်လက်ခံမည်မဟုတ်ကြောင်း ကြိုတင်အသိပေးအပ်ပါသည်။

Student's Name		Male	<input type="checkbox"/>
Date of Birth			
Height		Female	<input type="checkbox"/>
Weight			

Part I - To be completed by parents/ guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no". "Explain all "yes" answers in the space provided below.

Any health concerns	Y N	Hospitalization or Emergency Room visit	Y N	Concussion	Y N
Allergies to food or bee stings	Y N	Any broken bones or dislocations	Y N	Fainting or blacking out	Y N
Allergies to medication	Y N	Any muscle or joint injuries	Y N	Chest pain	Y N
Any other allergies	Y N	Any neck or back injuries	Y N	Heart problems	Y N
Any daily medications	Y N	Problems running	Y N	High blood pressure	Y N
Any problems with vision	Y N	Has only 1 kidney or testicle	Y N	Bleeding more than expected	Y N
Uses contacts or glasses	Y N	Excessive weight gain/ loss	Y N	Problems breathing or coughing	Y N
Any problems hearing	Y N	Dental braces, caps, or bridges	Y N	Asthma treatment (past 3 years)	Y N
Any problems with speech	Y N			Seizure treatment (past 2 years)	Y N
				Diabetes	Y N
				ADHD/ ADD	Y N

Please explain all "yes" answers here. For illnesses/ injuries/etc., include the year and/or your child's age at the time.

Part II ---- Medical Evaluation

Health Care Physician must complete and sign the medical evaluation and physical examination

Student Name : _____ Birth Date : _____ Date of Exam : _____

◆ I have reviewed the health history information provided in Part I of this form

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
Lymphatic			Shoulders		
Heart			Arms/ Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/ Ankles		
*Postural			<input type="checkbox"/> No spinal abnormality	<input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Marked	

List any medication(s) and dosage(s) :

Student's limitations teachers should know:

I have examined the above-named child and found him/ her to be in satisfactory health and free of communicable disease. In my opinion, he/ she is in suitable physical condition to participate in preschool activities.

Name of Health Care Physician

Signature

Date

Remarks :

Contact Information

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