JETS
Jewish Educational Trade School

ד"סב

PHYSICIAN'S MEDICAL REPORT

Patient's Name *(Last, First, M.I.):*	**DOB:** ____ /____ /____ (M / D / Y)
Physician's Name:	**Physician's Telephone:**
Has been a patient since: ____ /____ /____ (M / D / Y)	**Date of last physical exam:** ____ /____ /____ (M / D / Y)

PATIENT HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ TOPV	☐ Other

List any medical problems that this child has been diagnosed with

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List patients prescribed medications				**If none**
Name of medication	Strength	Frequency Taken	Reason Prescribed	This patient has not been prescribed any medication in the past 2 years _____ Initial

Allergies

Name the Allergen	Reaction

OTHER PROBLEMS

Check current or past symptoms in the following areas and briefly explain.

☐ Skin	☐ Lungs	☐ Stress related issues
☐ Eyes	☐ Chest/Heart	☐ Depression
☐ Ears	☐ Head/Neck	☐ Anxiety
☐ Nose	☐ Nervous System	☐ Eating disorder
☐ Throat	☐ Speech	☐ Insomnia
☐ Teeth	☐ Orthopedic	☐ Learning disorder

I hereby certify that the above information is true and correct to the best of my knowledge

Physician's Signature_____ Date_____ Medical License # _____

Form C1