



Physical Fitness Card

Name of the child _____ Blood group _____

Name of the Parent or Guardian _____

Address of the Parent or Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ___ Yes ___ If yes, what?

2. Is child currently under a doctor's care? No ___ Yes ___ If yes, for what reason? _____

3. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _____

4. Any previous hospitalization or operation? No ___ Yes ___ If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? No ___ Yes ___

Diabetes No ___ Yes ___; Convulsions No ___ Yes ___; Heart Trouble No ___ Yes ___;

If others, what / When? _____

6. Does the child have any physical disability? No ___ Yes ___ If yes, please describe: _____

Signature of the Parent/ Guardian

7. Any mental disability? No ___ Yes ___ if yes, please describe:

B. Physical Examination: (This examination must be completed and signed by a licensed physician.)

Height _____ cm Weight _____ kg

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ Abd /GU _____

Ext _____ Neurological System _____ Skin _____

Vaccination details:

Triple Antigen _____ Polio _____ BCG _____ Cholera _____ Small Pox _____

Typhoid _____ Measles _____ Jaundice _____ Chicken Pox _____

Should activities be limited? No ___ Yes ___ If yes, explain: _____

Any other recommendations: _____

Date of Examination _____

Signature of authorized examiner & Seal _____

Signature of the Parent/ Guardian