

Please return this form to:

Weechi-it-te-win Family Services
P.O. Box 812, Fort Frances, ON, P9A 3N1
Phone: (807)274-3201
Fax: (807)274-8435



INITIAL AND ANNUAL MEDICAL EXAMINATION FORM

Name of Child: _____ Date of Examination: _____

DOB: _____ Child Escort: _____

Position: _____

GENERAL CONDITION	COMMENT	GENERAL CONDITION	COMMENT
Height		G-U System	
Weight		Digestive System	
Skin		Locomotor System	
Eyes		C.N.S	
Nose		Genitals	
Tonsils		Menstruation	
Lymphatic System		Visual Acuity	
Cardiovascular		Hearing	
Respiratory		Speech	

Assessment/observations:

Medication and Treatment Recommendations:

Significant Family Medical History:

HISTORY OF PAST ILLNESSES	RESPONSE	COMMENT
ALLERGIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DRUG SENSITIVITIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHRONIC HEALTH PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	
LIMITS ON PHYSICAL ACTIVITY	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DIETARY ISSUES	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MAJOR OPERATIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	
OTHER ILLNESSES	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Name of Physician: _____ Signature: _____