



Medical Report Update (CONFIDENTIAL)

Please fill in this form and return it to the Division Secretary's Office.

Full Name				Date			
Class		Division		<input type="checkbox"/> No medical update for the past year			
A. Vaccinations							
Please Specify ONLY the dates of vaccines done last year							
Hepatitis A				Date: ____/____/____			
Hepatitis B				Date: ____/____/____			
Polio				Date: ____/____/____			
Triple Vaccine (DPT)/DT				Date: ____/____/____			
MMR (Measles, Mumps, Rubella)				Date: ____/____/____			
Tuberculin test (PPD.IDR)				Date: ____/____/____			
Meningitis (ACT HIB)				Date: ____/____/____			
Chicken Pox (Varicella)				Date: ____/____/____			
Pneumococcal Conjugate (PCV)				Date: ____/____/____			
Influenza				Date: ____/____/____			
Human Papillomavirus (HPV)				Date: ____/____/____			
B. Medical Diseases							
Disease Name	Yes	No	If yes, when	Disease Name	Yes	No	If yes, when
German Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____				
C. Hospitalization and/or Surgical Intervention							
Description							
D. Family Illnesses							
E. Miscellaneous Medical Instances							
Type	Yes	No	If yes, please specify				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>					
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>					
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>					
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>					
Eyesight Difficulties	<input type="checkbox"/>	<input type="checkbox"/>					
Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>					
Headaches	<input type="checkbox"/>	<input type="checkbox"/>					
Motor Problems	<input type="checkbox"/>	<input type="checkbox"/>					
Others	<input type="checkbox"/>	<input type="checkbox"/>					
F. Current Medications							
G. Accidents or Other Details							
In addition to the above, are there any other details you feel we should be aware of regarding your son's/daughter's health?							

Parent's or Doctor's Signature