# Карта Здоров'я - Physical Examination

Name ______________________________________________________ Date of Birth _________________

Address ____________________________________________________ Phone _______________________

City_________________________________________________________ State _____ Zip _______________

Date _________________________ Weight _________________________ Height ____________________

Eyes _________________________ Throat __________________________ Ears _____________________

Heart ___________________ Lungs ______________________ Other defects _______________________

Date of immunizations: DTP__________________ Polio _________________ Tetanus _________________

Allergies__________________________________________________________________________________

Previous Illnesses & Operations______________________________________________________________

Remarks _________________________________________________________________________________

_____________________________________________
Signature of Examining Physician

---

## Medical Insurance

Name of Insurance Company _________________________________________________________________

Name of Contract Holder ____________________________________________________________________

Policy Number_ _______________________________________ Group Number________________________

Emergency consent: I hereby give my consent for emergency medical treatment for my son/daughter.

_____________________________________________
Signature of Parent/Guardian

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)!