MEDICAL HISTORY

TO BE COMPLETED BY PARENT/GUARDIAN:

Child's Name_____ Age_____

Family Physician_____ Phone_____

Has your child had the following?

	YES	NO	YEAR		YES	NO	YEAR
Chicken Pox				Diabetes			
Scarlet Fever				Convulsions			
Strep Throat				Asthma			
Rheumatic Fever				Hepatitis			
Mononucleosis				Heart murmur			
Ear infection				Other_____			

Any allergies? If so, what kind?_____

Dental problem?_____

Hearing problem?_____

Vision problem?_____

Has your child had any?

	YEAR	EXPLAIN
Hospitalizations	_____	_____
Operations	_____	_____
Severe illness	_____	_____
Severe injuries (fractures,sprains,etc.)	_____	_____

Does your child take any medications on a regular basis? If so, what kind?_____

_____

Any other information that would assist us to help your child in school?

_____

_____

I do/do not (circle one) authorize the school nurse to release information to pertinent school personnel on health concerns/medical needs that might affect my child's safety or performance in the school environment.

Signature of
Parent/Guardian_____ Date_____