

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?

Signature of _____ Date _____
Parent/Guardian _____