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
Parent/Guardian_____Date_____