Student ID # ________________

Do Not Write In This Space

MEDICAL HISTORY

(To be completed by parent)

Student's Name: ______________________________ School/Grade: ____________________

Has your child ever had any of the following?

Condition	Yes	No
Seasonal Allergies	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chronic Cough	❑ Yes	❑ No
Chronic Fatigue	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Crohn's Disease/IBS	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No
Heart Condition	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Lyme Disease	❑ Yes	❑ No
Muscular Weakness	❑ Yes	❑ No
Prolonged Bleeding	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No

Please explain any "Yes" answers: ____

____

Has your child ever been hospitalized? ____________________ Had surgery? ____________________

Please explain (include child's age at the time): ________________________________

____

Does your child have any allergies? ____________ To what? ______________________

Does your child take any medication? __________ Why? __________________________

Name of medication? ____________________________ What time of day? ______________

Does your child wear glasses/contact lenses? ______________ For blackboard or reading? ____________

Is there anything else we should know about your child's medical history? ______________

____

Has your child been evaluated for a disability? ❑ Yes ❑ No If so, please describe: ______________

____

Has your child been classified by a Committee on Special Education as a student eligible for Special Education Services:

❑ Yes ❑ No If so, please describe: ____

____

Has your child received any special services (i.e.) Speech, OT, PT, AIS, ESL, etc.) in a previous school? ❑ Yes ❑ No

If so, please describe: ____

____

Parent/Guardian signature: X ______________________________ ***Date:*** ______________

Rev. 1/16