Student Name: **Birth Date:**

MEDICAL HISTORY

ALLERGIES: (Food, Drug, insect other)

Reaction:

MEDICATION (List all prescribed or over the counter taken on a regular basis)
Home:

School:

Diagnosis of Asthma? Y N ____Inhaler use? Y N ___ Home ___ School
Triggers:

Birth Defects	Y N	
Developmental Delay	Y N	
Blood Disorders? Hemophilia, Sickle Cell, Other. Explain	Y N	
Diabetes	Y N	Type:
__ Blood sugar testing __insulin injection __ insulin pump		
Head Injuries	Y N	
___ concussion (age & treatment) _____		
___skull fracture (age & treatment)		
Seizures	Y N	Please describe

Heart Problems

Shortness of Breath	Y N		
Heart Murmur	Y N	restrictions	Y N
High blood pressure	Y N		
Dizziness or chest pain with exercise	Y N	restrictions	Y N
Eye/Vision Problems	Y N	Last exam _____	
___Glasses ___ Contacts ___Amblyopia (lazy eye)			
___ Loss of Vision ___right eye ___left eye			
Ear/Hearing Problems	Y N		
___hearing loss ___right ear ___left ear			
___hearing aids ___right ear ___left ear			
Bone/Joint problems/ injury; scoliosis Please explain			

Loss of function of one of paired organs (eye; ear; kidney; testicle)	Y N	
Hospitalizations	Y N	please explain
Surgeries	Y N	please explain
Serious injury or illness	Y N	please explain
TB skin test positive	Y N	year_____
TB disease	Y N	year_____
treatment		
Family tobacco use	Y N	
Alcohol/Drug use	Y N	
Family history of sudden death before age 50; explain	Y N	

Dental: ___ Braces ___Bridge ___Plate
__other last exam:_____

Last medical exam _____

Physician:

Childhood Illnesses: ___ Chickenpox (yr)_____ ___Pertussis or Whooping Cough (yr)_____

Other Concerns:

Information may be shared with appropriate personnel for health and educational purposes. I further give permission for school medical personnel to contact my medical providers during the school year to clarify appropriate care for my child.

Parent/Guardian Signature _____

Date _____ Phone: _____