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?

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