Medical History Form

Please complete this form for each child so we can update your child's health records from the previous year. Thank You!

Student's Name:_____Grade/Homeroom_____

Vision (Eyes): Glasses_____(reading_____distance_____) Contacts_____
comments:_____
Hearing: frequent infections_____tubes_____
hearing difficulty (explain)_____
hearing aid – right___left___wears at school_____

Allergies: (drugs, food, insects, pollens)
Please list:_____
Has the allergy ever required emergency action? (explain)_____
_____

Asthma: Yes_____No_____Triggered by:_____
Treatments:_____
Exercise Limitations:_____
Diagnosed by physician (date):_____

Seizures: Yes_____No_____Date of last seizure:_____
Describe seizure:_____
Medications:_____

Other medications and reason for taking:_____
_____
_____

Other Health Concerns:
diabetes_____heart problems_____blood disorder_____eating_____sleeping_____
bowel_____bladder_____bed wetting_____menstrual history_____
phobias (fears)_____lungs_____skin_____blood pressure_____orthopedic___
neurologic_____TB exposure_____sickle cell anemia___headaches_____
Explain:_____
_____
_____

Other illness, injury or health problem that might affect performance at school:_____
_____

Parent/Guardian:_____Date:_____