

Student: _____ Date completed: _____

MEDICAL HISTORY

To be completed by parent or guardian.
Please give this form careful thought and fill out entirely.

Is your child known to be resistant to any antibiotics? _____

Allergies to:

Drugs: _____ Food: _____ Seasonal Allergies: _____

Has student received any counseling or psychological care? Yes: _____ No: _____ When? _____

Date of last dental exam: _____ Orthodontia in progress? _____

Date of last eye exam: _____ Prescription glasses: Yes: _____ No: _____ Contacts? Yes: _____ No: _____

Please enclose copy of lens prescription (students required to wear glasses for sports must have glasses which comply with ANSI Z 87.1 standard, or they will not be allowed to participate).

Are you a vegetarian? Yes: _____ No: _____ Vegan? Yes: _____ No: _____ Any dietary restrictions? Yes: _____ No: _____

Explain dietary restrictions: _____

Please provide names, ages, and state of health of family member's

Mother: _____ Father: _____

Brother: _____ Sister: _____

Serious illnesses or diseases occurring in family (such as TB, diabetes, heart diseases, kidney, cancer, stroke, high blood pressure): _____

Important occurrences and dates in family: Deaths: _____

Divorce: _____ Adoption: _____ Other: _____

Does your child have now or has he/she ever had any of the following? Please check the items that apply and comment below.

<input type="checkbox"/> Measles	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Gastro-Intestinal Problems
<input type="checkbox"/> Mumps	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Deformities
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Serious Injuries
<input type="checkbox"/> German Measles	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Hernia
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Bone/Joint Problems
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sinusitis/Bronchitis	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Foot Problems
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Operations/Serious Injuries
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Orthodontia	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Polio	<input type="checkbox"/> Gum/Tooth Problems	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Speech Problems	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Painful Urination/UTI
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Learning Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Depression./Anxiety	<input type="checkbox"/> Nutritional Problems	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Skin Problems

Comments: _____

Is there anything else about your child's health that we need to know? _____

Does your child have a history of tobacco use or drug abuse? _____

Parent/Guardian's Signature: _____