

Medical History

Student: _____ Birth date: _____ Sex: M / F
 First Middle Last

Place of Birth: _____ Social Security #: _____

Father: _____ List any pertinent history of family disease:
 First Middle Last

Mother: _____
 First Middle Last

Has the student had a history of :
 Y N

List any Allergies:

AIDS	_____	_____
Asthma	_____	_____
Chicken Pox	_____	_____
Diabetes	_____	_____
Fainting	_____	_____
Frequent Colds	_____	_____
Frequent Sore Throat	_____	_____
Frequent Urination	_____	_____
Heart Disease	_____	_____
Hepatitis	_____	_____
Measles	_____	_____
Mumps	_____	_____
Nose Bleeds	_____	_____
Persistent Cough	_____	_____
Poor Vision	_____	_____
Seizures	_____	_____
Shortness of Breath	_____	_____
Tuberculosis	_____	_____

List any medications student is currently taking:

List any disabilities or other diseases:

Date of last TB Test: _____

Parents must provide a copy of the child's immunization record.

Students who show symptoms of a communicable disease will be excluded from classes until readmission is acceptable to school authorities.

Name of Family Doctor: _____ Doctor's Phone: _____

Parent Signature: _____ Date: _____