
MEDICAL HISTORY

(Check all that apply)

Asthma _____ Heart Condition _____ Seizure Disorder _____ Diabetes _____

Does your child have any physical, learning, or other disability that the school should be aware of in order to help your child achieve his/her education goals? Yes: _____ No: _____
If yes, please describe: _____

Is your child allergic to anything? Yes: _____ No: _____
If yes, please describe: _____

Drugs allergies (please list) _____

Food Allergies (please list) _____

Does your child require an Epi-pen for allergic reactions? Yes: _____ No: _____

Is your child currently being treated for any medical condition? Yes: _____ No: _____
If yes, please describe: _____

Is your child currently on any medication(s)? Yes _____ No _____
If yes, please list medications: _____

In the past year has your child had a serious illness or accident that required hospitalization?
If yes, please explain: _____

Your child's physician: _____

Date of next or last appointment: _____

Your child's dentist: _____

Date of next or last appointment: _____

(Please fill out both sides of this form completely)