

# MEDICAL HISTORY

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*(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 describe \_\_\_\_\_

In the past year has your child had a serious illness or accident that required hospitalization?

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

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)***