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 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)