Medical History Form

Student's Name: _____ Grade: ____

Vision (Eyes): Glasses _____ (reading ____ distance ____) Contacts _____
comments: _____
Hearing: frequent infections _____ tubes _____
hearing difficulty (explain) _____
hearing aid - right _____ left _____ wears at school _____

Allergies: (drugs, food, insects, pollens)
Please list: _____
Has the allergy ever required emergency action? (explain) _____
_____

Asthma: Yes ____ No _____ Triggered by: _____
Treatments: _____
Exercise limitations: _____
Diagnosed by physician (date): _____

Seizures: Yes ____ No _____ Date of last seizure: _____
Describe seizure: _____
Medications: _____

Other medications and reason for taking: _____
_____
_____

Other Health Concerns:
diabetes ____ heart problems ____ blood disorder ____ eating ____ sleeping ____ bowel ____ bladder ____ bed wetting ____ menstrual history _____ phobias(fears) ____ lungs ____ skin ____ blood pressure ____ orthopedic ____ neurologic ____ TB exposure ____ sickle cell anemia ____ headaches ____
Explain: _____
_____
_____

Other illness, injury, or health problem that might affect performance at school: _____
_____

Parent/Guardian: _____Date: _____