

STUDENT MEDICAL HISTORY

NAME _____

DATE OF BIRTH _____

ALLERGIES _____

CURRENT MEDICATIONS

MEDICINE	DOSE	REASON	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

DIABETES ___	VISION PROBLEMS ___	HEARING PROBLEMS ___
ANEMIA ___	SEIZURES ___	TUBES IN EARS ___
HEADACHES ___	BOWEL PROBLEMS ___	BLADDER PROBLEMS ___
DEPRESSION ___	ADHD ___	FREQUENT SORE THROATS ___
EPILEPSY ___	SEASONAL ALLERGIES ___	FREQUENT STOMACHACHES ___
MEASLES ___	MUMPS ___	SCARLET FEVER ___
SPEECH DIFFICULTIES ___	BRONCHITIS ___	PNEUMONIA ___
CHICKEN POX ___	KIDNEY DISEASE ___	SCOLIOSIS ___
GLASSES ___	CONTACTS ___	

SOCIAL HISTORY

SHY ___	OVERACTIVE ___	TIRES EASILY ___
ANGERS EASILY ___		

SIBLINGS

NAME

AGE

DOCTOR _____

OTHER INFORMATION YOU FIND PERTINENT TO YOUR CHILD'S HEALTH AND WELL-BEING _____

CONTACT IN CASE OF EMERGENCY

NAME

NUMBER

RELATIONSHIP
