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*

_____
_____
_____