



MEDICAL INFORMATION

2022-2023

Name: _____

Birth Date: _____ Entering Grade: _____

Check if the student has had any of the following. Give dates of any positive answer.

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Concussion/Head Injury | | <input type="checkbox"/> Other |

Explanations:

Check if the student has had any of the following. Please explain any positive answers.

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Hearing Loss/Defect | <input type="checkbox"/> Bladder Problem | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hernia | |

Explanations:

3. Is the student on any medications? Yes No

Specify _____

4. Does your child have any physical limitations which might require some adjustments to a normal student activity schedule? _____

If yes, please describe: _____

5. Has your child had any operations? Yes

No

If yes, please describe:

6. Does your child have any allergies? Yes No

If yes, please describe; _____

7. Has your child ever been treated for any nervous, mental, or emotional disorder? Yes No

If yes, when and how long a period _____

8. Is there any other medical information about your child that you think we should have?
