

Student Medical History

Student's Name _____
Last First Middle

Address _____
House No. Street Name Apt. No.
_____ City State Zip Code

Please check any of the following conditions affecting your child:

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Ear Problems | |

Please explain any of the item checked above: _____

Please list any allergies that affect your child: _____

Indicate any other health condition(s) your child has in which the school should know about. Include any health conditions that may require special attention from the school.

Parent/Legal Guardian's Signature _____

Date _____

