Medical History Form

DOES THE STUDENT HAVE:	YES	NO
Allergies	___	___
Diabetes	___	___
Epilepsy or Convulsions	___	___
Heart Problems	___	___
Loss of Hearing	___	___
Loss of Eyesight	___	___

Please provide detail:

Has the student ever had a surgery? ___ ___

Does the student wear glasses? ___ ___

Does the student wear contact lenses? ___ ___

Has the student received Immunization against the following:			Date of Immunization
Polio	___	___	_____
Pertussis (Whooping Cough)	___	___	_____
Mumps	___	___	_____
Measles	___	___	_____
Rubella	___	___	_____
Diphtheria	___	___	_____
Tetanus	___	___	_____

Has the student ever contracted any diseases (e.g. tuberculosis?)

Please provide detail:

Are there any other health concerns school should be aware of ?

Student's name & signature: _____

Parent's name and signagure: _____ Date: _____

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