MEDICAL HISTORY OF CHILD

Student Name ______________________________

Parent Name ______________________________

☐ Chicken pox	☐ Flu	☐ Meningits	☐ Whooping cough
☐ Convulsions	☐ Measles	☐ Mumps	☐ Other: ______

Allergies *(foods, etc) (Physician documentation of all allergies required)* ☐ Yes ☐ No If yes, explain: ______

____

Any Evidence of hearing loss or difficulties? ☐ Yes ☐ No If yes, explain: ______

____

Any evidence of vision difficulties? ☐ Yes ☐ No If yes, explain: ______

____

Speech disabilities? ☐ Yes ☐ No If yes, explain: ______

Hospitalizations? ☐ Yes ☐ No If yes, explain: ______

Operations? ☐ Yes ☐ No If yes, explain: ______

Other illness? ☐ Yes ☐ No If yes, explain: ______

Does your child have any physical handicaps? ☐ Yes ☐ No If yes, explain: ______

Does your child have any special needs that may affect his schoolwork? ☐ Yes ☐ No If yes, explain: ______