

MEDICAL HISTORY FORM

Student's Name: _____ Date of Birth: _____ Grade: _____

Instructions to Parent/Guardian:

Please provide the following information about your child and return this form to the health office. If you have specific health conditions, please call me at 856-546-1473 to discuss your concerns.

1. Please check any of the following that your child has had.

- | | |
|---|---|
| <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Orthopedic Problems/Injuries | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> allergies | <input type="checkbox"/> chicken pox |

2. Please check all of the following areas in which your child has problems

- | | |
|--|---|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Playing with other children |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Following verbal directions | <input type="checkbox"/> Walking, running, balance, holding objects, other motor skill problems |

3. Is your child frequently sick? ___ Yes ___ No If yes, what is the most common cause of the problem?

4. Is there anything about your child's health, habits, or behaviors that you would like to tell us?

5. Does your child take medication regularly? ___ Yes ___ No if yes, please list

9. Health Insurance Provider _____

Provider ID number _____

10. If you do not have health insurance check here