

Sussex-Wantage Regional School District

Parent Medical Questionnaire

Child's First Name: _____ Last Name: _____

Date of Birth: _____ Date of Last Physical: _____

Parent Name: _____

Phone Number: _____

Medical History:

Reactions to Immunizations (type)? _____

Allergies (food, medication, other)? _____

Drug Sensitivities (type)? _____

Congenital Defects (type)? _____

ADD/ADHD (type)? _____

Use Inhaler or Nebulizer? _____

Seizure/Convulsive Disorder (type)? _____

Diabetes? _____

Heart Disease? _____

Frequent Ear Infections? _____

Frequent Strep Infections? _____

Fractures (year and location)? _____

Current Medications? _____

Any Other Medical Conditions? _____

Parent Signature: _____ Date: _____