

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This form is to be completed by a parent or guardian.

1. Does your child have any of the following problems? **Please ✓ all those apply.**

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Known vision and hearing loss |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Contact with tuberculosis     |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Known allergies               |
| <input type="checkbox"/> Kidney trouble          | <input type="checkbox"/> Any handicaps                 |
| <input type="checkbox"/> Heart trouble           | <input type="checkbox"/> Repeated pneumonias           |
| <input type="checkbox"/> Blood disorders         | <input type="checkbox"/> Behavior problems             |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Hyperactivity                 |

2. Other health problems?

---



---

3. Has your child had any operations, serious accidents, or hospitalizations?

Yes  No Explain: \_\_\_\_\_

---

4. Does your child take medications?

Yes  No Name of medication: \_\_\_\_\_

5. Please ✓ any of the following childhood illnesses your child has had:

- |   |                                     |                                      |                                  |
|---|-------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Measles    | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Tetanus |

6. Has your child had any dental problems and/or toothaches?

Yes  No

7. Has your doctor recommended any restrictions of activity for this child?

Yes  No Explain: \_\_\_\_\_

8. Name of your child's doctor or clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

---