

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: _____
