

GARDEN COUNTY SCHOOLS
MEDICAL HISTORY FORM

STUDENT _____ BIRTHDATE _____

PARENTS _____

ADDRESS _____ PHONE _____

OTHER EMERGENCY PHONE _____

PHYSICIAN _____ PHONE _____

DENTIST _____ PHONE _____

OPTOMETRIST _____ PHONE _____

A. MEDICAL HISTORY (CHECK ALL THAT APPLY TO YOUR CHILD)

- | | |
|--------------------------------------|--|
| _____ Breathing Problems | _____ Frequent sore throats |
| _____ Asthma | _____ Hay Fever |
| _____ Diabetes | _____ Bleeds easily |
| _____ Heart disease | _____ Seizures ** |
| _____ Bone disease | _____ Vision Problems |
| _____ Skin problems | _____ Eczema |
| _____ Pneumonia | _____ Tonsilitis |
| _____ Frequent earaches | _____ Frequent colds |
| _____ Hoarseness | _____ Mouth breather |
| _____ Hearing problems | _____ Speech difficulty |
| _____ Convulsions with fever | _____ Fainting spells |
| _____ Frequent nose bleeds | _____ Tubes in ears |
| _____ Rheumatic fever | _____ Tires easily |
| _____ Frequent headaches | _____ Frequent stomachaches |
| _____ Poor appetite/Eating disorders | _____ Frequent urinary tract infection |
| _____ Clumsiness | _____ Dental problems |
| _____ Color blindness | _____ Other vision problems |

**Are seizures _____ Petit mal _____ Grand mal _____ Psychomotor _____ Partial

Please tell us about any checked:

B. ALLERGIES

_____ Dust _____ Mold _____ Bees _____ Cut grass _____ Pollens
_____ Foods _____ Drugs _____ Animal _____ OTHER _____

Detail:

C. MEDICATIONS

1. List medications you child takes:

2. Does your child need the medication:

- a. At home? _____ Yes _____ No
- b. At school? _____ Yes _____ No

D. Is there a health problem and/or handicap present? _____ Yes _____ No

What is the diagnosis? _____

At what age was the diagnosis made? _____

List the physician who made the diagnosis _____

E. Describe any operations, injuries, or hospitalizations and give their dates:

F. Does your child's condition restrict his/her participation in any physical education activity?

- _____ Yes _____ No

G. Does your child wear glasses? _____ Yes _____ No
Contact lenses? _____ Yes _____ No

H. Last eye exam (date): _____ By: _____
Last dental exam (date): _____ By: _____
Last medical exam (date): _____ By: _____

The following information will help the school staff understand your child better:

Describe your child today, what is he/she like?

Do you have any concerns about your child or do you wish help in working with any problems you feel your child has?

Thank you for taking the time to fill out this medical history form. In the event your child's medical information changes, please contact the school at (308) 772-3336.

Date

Parent Signature