

Student Medical History / Information Form

Please complete this form so staff and health providers can be aware of and best care for your health needs. If necessary, describe in detail any physical and/or psychological ailment, illness, susceptibility, weakness, limitation, handicap, disability, or condition to which you are subject to. Please list any action or protection that may be required to care for your needs.

Please circle any of the following conditions that you may have:

ALLERGIES:

Bee Stings

Penicillin

Dairy

Poison Ivy, Oak, Sumac

Nuts

Pollen

Peanuts

Other Drugs/Medications: _____

Other: _____

MEDICAL CONDITIONS:

Asthma

Hypo - glycemia

Diabetes

Motion Sickness

Eczema

Nose Bleed

Epilepsy

Upset Stomach

Fainting

Seizures

Headaches

Other: _____

Heart

SPECIAL CONDITIONS:

ADD

Fears

ADHD

ODD

Anxiety

Sleeping disorders

Bi- polar

Hearing Impairment

Glasses or Contact lenses

Physical handicap

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Do you have any condition that might prevent you/your child from participating in any particular activity?

No Yes (if yes, please explain) _____

For your safety please circle one of the following that best describes you:

Good swimmer Fair swimmer Non swimmer

Date of your last tetanus shot: _____ Blood type: _____

Please list any specific care you may need in the event of a medical emergency concerning any of the previously selected conditions:

Please list any medications and doses that you are taking:
