

Student's Full Name _____

Student's Cell # _____ Nick Name: _____

Sex: _____ Birth Date: _____ Grade (fall): _____

Address: _____

City, St Zip _____

Medical History

Please answer NO (N) or YES (Y) to each of the following:

1. Is your son/daughter currently taking medication of any type? N Y Self administered? Y
If yes, please specify: _____

2. Does your son/daughter have any allergic reactions ? N Y If yes, please indicate:

A. Aspirin	<input type="checkbox"/>	D. Tetracycline	<input type="checkbox"/>	G. Food	<input type="checkbox"/>	Specify: _____
B. Penicillin	<input type="checkbox"/>	E. Insect Stings	<input type="checkbox"/>			
C. Sulfur	<input type="checkbox"/>	F. Latex	<input type="checkbox"/>	H. Other	<input type="checkbox"/>	Specify: _____

3. Has he/she ever been treated or is currently being treated for:

A. Asthma	<input type="checkbox"/> N	<input type="checkbox"/> Y	H. Arthritis	<input type="checkbox"/> N	<input type="checkbox"/> Y	O. Contact Lenses	<input type="checkbox"/> N	<input type="checkbox"/> Y
B. Epilepsy	<input type="checkbox"/> N	<input type="checkbox"/> Y	I. High Blood Pressure	<input type="checkbox"/> N	<input type="checkbox"/> Y	P. Braces / Retainers	<input type="checkbox"/> N	<input type="checkbox"/> Y
C. Diabetes	<input type="checkbox"/> N	<input type="checkbox"/> Y	J. Migraines/Headaches	<input type="checkbox"/> N	<input type="checkbox"/> Y	Q. Other Prosthetic Devices	<input type="checkbox"/> N	<input type="checkbox"/> Y
D. Fainting Spells	<input type="checkbox"/> N	<input type="checkbox"/> Y	K. Depression	<input type="checkbox"/> N	<input type="checkbox"/> Y	T. Any Other Medical Disorders	<input type="checkbox"/> N	<input type="checkbox"/> Y
E. Heart Conditions	<input type="checkbox"/> N	<input type="checkbox"/> Y	L. Anxiety	<input type="checkbox"/> N	<input type="checkbox"/> Y	If YES, specify: _____		
F. Rheumatic Fever	<input type="checkbox"/> N	<input type="checkbox"/> Y	M. Ulcers	<input type="checkbox"/> N	<input type="checkbox"/> Y	_____		
G. Cancer or Tumor	<input type="checkbox"/> N	<input type="checkbox"/> Y	N. Sensitivity to the Sun	<input type="checkbox"/> N	<input type="checkbox"/> Y			

4. Surgery/Procedures/Illness:

Recent (within 1 year): _____

Past (greater than 1 year ago): _____

5. Please list any special health concerns or instruction: _____

Family Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health Insurance Company: _____ Policy # _____ Group # _____

Dental Insurance Company: _____ Policy # _____ Group # _____

Please note any special instructions regarding insurance/approval requirements.

Mother/Guardian's Name: _____ Father/Guardian's Name _____

Home Tel: _____ Home Tel: _____

Cell Tel: _____ Cell Tel: _____

Emergency Contact Person: _____ Tel: _____

This is permission for the treatment of a child by a physician and at a hospital for any medical or surgical emergency.

Signature of Parent/Guardian _____ Date _____

Witness _____ Date _____