2B

MEDICAL HISTORY FORM

CHILD'S NAME_____ AGE_____ GRADE_____

ALLERGIC TO MEDICINE OR FOOD?_____

TYPE OF REACTION _____

*PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING:

____ASTHMA _____SEASONAL ALLERGIES _____VISION/HEARING PROBLEMS

____HEART CONDITION _____DIABETES _____ ADHD, ADD

IS YOUR CHILD ON ANY MEDICATIONS/FOR WHAT? _____

_____

ANY HOSPITALIZATIONS IN THE LAST YEAR/FOR WHAT?_____

_____

DID YOUR CHILD RECEIVE ANY IMMUNIZATIONS OVER THE SUMMER.

_____

***Please be aware that you must send in a note FROM THE DOCTOR with the name of the vaccine and date

ANY OTHE CONCERNS I NEED TO KNOW ABOUT YOUR CHILD'S HEALTH

_____

_____

parent signature_____date_____