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