Name _____
School _____

Student Medical Form

Name _____ Age _____
Address_____ City_____ State____ Zip_____
Date of Birth___-___-___ Sex___ Weight_____ Height___ft___in

Parents or Guardians_____
Home Phone (_____)_____-_____ Work Phone (_____)_____-_____
Home Phone (_____)_____-_____ Work Phone (_____)_____-_____
Cell Phone (_____)_____-_____ Cell Phone (_____)_____-_____
Family Physician/Doctor_____ Phone (_____)_____-_____
In case of emergency, notify the following if a parent cannot be reached:
Name_____ Relationship_____ Phone (_____)_____-_____
Name_____ Relationship_____ Phone (_____)_____-_____

These must be filled in.

Home and Health Questionnaire

1. Please give the date of the student's last diphtheria-tetanus or tetanus booster _____.
2. Please list any current activity restrictions or special health concerns such as recent sprains, fractured bones, recent hospitalizations, learning disabilities, physical disabilities, special diet (vegetarian; vegan; no beef/pork; gluten, egg, or milk free, no food dye, religious restrictions, etc.)

_____
_____
_____

3. Does the student have a history of: (check all that apply)

____Asthma
____Bedwetting
____Bleeding disorder
____Constipation
____Diabetes
____Ear/Throat infections
____Emotional/psychological condition
____Fainting
____Hearing impairment
____Heart defect/disease
____Menstrual cramps
____Musculoskeletal disorder
____Seizures
____Sleep disturbances
____Homesickness
____Other health conditions:

Explain the health conditions checked above: _____
_____
_____

4. Please tell us if your student has any allergies: (Food, Medication, Insect Bite/Sting, Seasonal, Other)
My child is allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other**_____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc)_____
_____
Recommended **treatment** for reaction_____

My child is **ALSO** allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other**_____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc)_____
_____
Recommended **treatment** for reaction_____
Please list any additional allergies on the back of this form.