HEALTH FORM

NAME *(first, middle, last)*..... **Male / Female**

D.O.B. *(dd/mm/yyyy)*..... **Grade:**.....

Childs' primary physician and contact #:.....

THIS FORM IS TO BE COMPLETED, SIGNED AND STAMPED BY A MEDICAL DOCTOR

MEDICAL HISTORY

Check the conditions that apply and give further information

☐ ADD / ADHD (please explain).....
.....

☐ Headaches (please explain).....
.....

☐ Anxiety/Panic attacks (please explain).....
.....

☐ Heart condition (please explain).....
.....

☐ Kidney/Urinary tract - not limited
☐ Bowel problems - limited
☐ Muscular disorder
☐ Diabetes
☐ Color blindness
☐ Seizures
☐ Orthopedic problems
☐ Emotional concerns
☐ Vision problems
☐ Asthma
☐ Any other **medical condition**(s) that you think the school should be aware of:.....
.....
.....
.....

ASTHMA

If you checked asthma, please answer the following:

☐ YES ☐ NO Does this child take daily asthma prescription medication? (not including albuterol)
☐ YES ☐ NO Does this child take more than 2 asthma medications daily?
☐ YES ☐ NO Has this child been to the ER for asthma in the past 12 months?
☐ YES ☐ NO Has this child used steroids in the past year for asthma symptoms?
☐ YES ☐ NO Do asthma symptoms interfere with sleep?
☐ YES ☐ NO Does this child have asthma symptoms more than 3 days a week?

ALLERGIES

List allergies that this child has that may cause a problem at school:

Cause of allergy: .....
Treatment: .....

Cause of allergy: .....
Treatment: .....

VISION

Does this child wear prescription lenses? .....

.....

Name, address and # of physician .....

.....

HEARING

Does this child wear a hearing aid? .....

.....

Name, address and # of physician .....

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ANY OTHER INFORMATION

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I have this day examined ……..……..and have found that he/she has no disease or infirmity which would render him/her unsuitable for school. His/her age is ……and by appearance he/she has been fully immunized.

Dated at……on the ……..of …….. 20……

…….

Physicians signature Stamp/seal