

STUDENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ GRADE: \_\_\_\_\_

Has your child ever been **diagnosed** with any of the following medical conditions?  
Indicate any medications your child has been prescribed for any of the following.

MEDICAL CONDITION:

MEDICATION:

\_\_\_ Asthma

\_\_\_\_\_

\_\_\_ ADD/ADHD/Bipolar/ODD

\_\_\_\_\_

\_\_\_ Seizure Disorder

\_\_\_\_\_

\_\_\_ Heart Condition

\_\_\_\_\_

\_\_\_ Migraine Headache

\_\_\_\_\_

\_\_\_ Cerebral Palsy

\_\_\_\_\_

\_\_\_ Diabetes

\_\_\_\_\_

\_\_\_ Acute Allergic Reaction to

Food \_\_\_\_\_

\_\_\_\_\_

Drug \_\_\_\_\_

\_\_\_\_\_

Bee Sting \_\_\_\_\_

\_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

yes no

Will your child take any medication while at school?  
(If yes, appropriate forms MUST be submitted)

Does your child wear glasses?

Does your child have any hearing problems?

Has your child had the chickenpox?

Family physician: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_