

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 _____