Child's Medical History

Child's Name:_____

At what age has the child had any of the following diseases?

Chicken Pox_____	Mumps_____	Rheumatic Fever_____
Measles_____	Strep_____	Scarlet Fever_____
German Measles____	Hepatitis_____	Other_____

At what age has the child had any of the following operations?

Tonsillectomy_____	Hernia repair_____
Appendectomy_____	Other_____

Does the child have any medical history of the following:

	Yes	No		Yes	No
Allergies	___	___	Frequent urinary infections	___	___
Convulsive disorders	___	___	Frequent sore throats	___	___
Diabetes	___	___	Poisoning	___	___
Physical disability	___	___	Serious burns	___	___
Kidney disorder	___	___	Cuts needing a doctor	___	___
Heart disorder	___	___	Broken bones	___	___
Fainting	___	___	Physical abnormality	___	___
Asthma	___	___	Persistent mouth breathing	___	___
Frequent headaches	___	___	Frequent digestive disturbance	___	___
Frequent colds	___	___	Frequent pain: Joints	___	___
			Muscular	___	___
			Other	___	___

If yes to any of the above, please give details:_____

_____

Has the child ever had vision examined professionally?	Yes ___	No ___
Did the child ever have an eye injury?	Yes ___	No ___
Has the child ever had vision questioned in preschool screening?	Yes ___	No ___
Has the child ever had hearing examined professionally?	Yes ___	No ___
Did child have frequent ear infections during first five years?	Yes ___	No ___

If so, how was it treated? Tubes in ears ___ Medication ___ Both ___

If you child presently taking medication? If so specify reason and kind.

_____

Is your child under medical treatment at present? If so specify.

_____

Please indicate any physical condition you feel the school should be aware of.

_____

Has your child ever had a professional dental exam? Yes ___ No ___