

*(To Be Completed By Parent)*

Child's Name	Date of Birth	Age	Homeroom
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1. **Health Conditions:** Please check any of the following health conditions that your child has had:

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal spinal curvature                | <input type="checkbox"/> Heart Disease            |
| <input type="checkbox"/> Allergies or Hay Fever                   | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Lungs                                    | <input type="checkbox"/> Kidney Disease           |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Meningitis/ Encephalitis |
| <input type="checkbox"/> Behavior/ Emotional Problems             | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Birth or Congenital Malformations        | <input type="checkbox"/> Seizure/ Epilepsy        |
| <input type="checkbox"/> Cancer, Type _____                       | <input type="checkbox"/> Sickle Cell Disease      |
| <input type="checkbox"/> Cystic Fibrosis                          | <input type="checkbox"/> Skin Rashes (Frequent)   |
| <input type="checkbox"/> Diabetes (Type I/ Type II)               | <input type="checkbox"/> Diarrhea (Chronic)       |
| <input type="checkbox"/> Frequent Throat Infections               | <input type="checkbox"/> Constipation (Chronic)   |
| <input type="checkbox"/> Abdomen/ Hernia                          | <input type="checkbox"/> Stool Soiling            |
| <input type="checkbox"/> Wetting (daytime/ nighttime)             | <input type="checkbox"/> Tics/ Nervous Twitches   |
| <input type="checkbox"/> Urinary Infections (Frequent)            | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Ear Infections (Frequent)                | <input type="checkbox"/> P.E. Tubes               |
| <input type="checkbox"/> Eczema                                   | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Concerns about relationships with others | <input type="checkbox"/> Arthritis                |

Please comment on any of the above that you have checked: \_\_\_\_\_  
 \_\_\_\_\_

2. **Illnesses and Injuries:** List any serious illnesses or injuries

Illness/ Injuries	Child's age	Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments: \_\_\_\_\_  
 \_\_\_\_\_

3. **Medications:**

Are any medications given daily? If so, what are they? \_\_\_\_\_  
 Are any medications given frequently? If so, what are they? \_\_\_\_\_

4. **Activity:**

Is this child usually: very active \_\_\_\_\_ normally active \_\_\_\_\_ inactive \_\_\_\_\_  
 Does this child wear glasses? \_\_\_\_\_ Date of last vision exam: \_\_\_\_\_  
 Do you have any concerns about how this child interacts with others? \_\_\_\_\_

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like to share with the school? If yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

Does this child always wear seatbelts in cars? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Date of last dental exam \_\_\_\_\_

Completed by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_