



**Today's Date:** \_\_\_\_\_

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_ Date of Student's last Physical \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

#	QUESTION	YES	NO
1.	Ever hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Ever had major surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Ever had a serious injury?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Takes medication daily? (if yes, what?)..... Requires medication at School?.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5.	Ever had heart disease, murmur, irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Wears glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Ever had kidney/liver disease or enlarged organ?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Ever had asthma or lung disease (carries inhaler?)	<input type="checkbox"/>	<input type="checkbox"/>
10.	Any bleeding tendency, blood disease, anemia?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Any allergies (bee sting, food, latex, medication?)..... Has allergy required emergency treatment?..... Do you carry an Epi-Pen?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12.	Every had loss of eye, kidney, testicle, or other organ?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Is diabetic or hypoglycemic?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Ever had loss of consciousness, fainting, concussion, or frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Ever have severe or recurrent chest pains?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Ever have difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Hearing impaired?		
18.	Has impaired use of arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Has consulted with physician in past 6 months regarding any physical condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Has any condition that may be worsened by playing sports or physical education?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Any reason should not participate in all sports?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Has any condition that would be considered life threatening?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Has severe or chronic medical condition that requires special accommodations in a school setting?	<input type="checkbox"/>	<input type="checkbox"/>

**Please explain "Yes" answers to above questions (Give Dates)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Explain all "Yes" answers. Give dates.

Diseases	YES	NO		YES	NO
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections (frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A or B	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat (frequent)	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>

Conditions	YES	NO		YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Illness	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Language Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Paired Organ	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>

Difficulty with: Eating  Hearing  Speaking  Swallowing  Vision  Walking

Please explain "Yes" answers to above questions (Give Dates) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medication Information**

**PLEASE NOTE:** Any medication given at school (Prescription or non-prescription) requires a doctor's order, parent's authorization and parent has to deliver medication to the school nurse in a labeled prescription bottle with picture.

This information may be shared with appropriate faculty/staff members. Yes  No

Parent Signature: \_\_\_\_\_

Revised 10/6/09