Torah Day School of Atlanta
HEALTH HISTORY

Student's Full Name____

Gender: M ____ F ____ Age _____ Birth Date _____________

MEDICAL HISTORY

List medication to which you are allergic and give dates and descriptions of reactions. (If "none" please indicate.)

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List and give dates of any major illnesses or hospitalizations student has had. (If "none" please indicate.)

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List and give dates of significant injuries or surgery. (If "none" please indicate)

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List medication student is taking. (Prescription, allergy injections, herbals, etc. If "none" please indicate.)

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DOES STUDENT HAVE A PRESENT OR PAST HISTORY OF: (Check item that applies)

Yes	No		Yes	No	
		Eye Problems			**Congenital birth defects**
		Ear/Nose/Sinus Problems			**Cancer or malignancy**
		Infectious Mononucleosis			**Non-malignant tumor**
		Asthma			**Thyroid Disorder**
		Bronchitis			**Diabetes**
		Tuberculosis			**Epilepsy or seizures**
		Other lung infection			**Headaches**
		Heart murmur			**Depression**
		Chest pain			**Anxiety or tendency to worry**
		Rapid heart rate			**Skin problems**
		Fainting during or after exercise			**Anemia or blood disorder**
		High blood pressure			**Blood clotting problems**
		Recurrent diarrhea			**Chicken pox**
		Colitis/Enteritis			**Back Problems**
		Hepatitis: Type____			**Bone or Joint Problems**
		Bladder or kidney infection			**Sports-related injuries**
		Kidney Stone			**Alcohol or Drug Use**
		Gynecological Problems			**Eating Disorder**
		Herpes/other genital infections			**Other_______________________________**

*If **"yes"** is answered to any of the above, please explain and provide dates, treatments, complications, etc.*

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By my signature below, I attest that all statements in the medical record are true to the best of my knowledge and that my child has no health problems or medical restrictions not listed on this record.

Signature of Parent or Guardian _______________________________________**Date**________________