BUCKLEY COUNTRY DAY SCHOOL
2014-2015
GENERAL MEDICAL QUESTIONS

CHILD'S NAME: _____ GRADE: _____

Has/does the child:

	YES	NO		YES	NO
1. Have any recent injury, illness or infectious disease?			14. Ever had high blood pressure?		
2. Have a chronic or recurring illness/condition?			15. Ever been diagnosed with heart murmur?		
3. Ever been hospitalized?			16. Have an orthodontic appliance brought to school?		
4. Ever had surgery?			17. Have any skin problems (e.g. itching, rash, acne)?		
5. Have frequent headaches?			18. Have diabetes?		
6. Ever had a head injury?			19. Have asthma?		
7. Ever been knocked unconscious?			20. Had mononucleosis in the past 12 months?		
8. Wear glasses, contacts, or protective eye wear?			21. Had problems with diarrhea/constipation?		
9. Ever had frequent ear infections?			22. Ever had an eating disorder?		
10. Every passed out during or after exercise?			23. If female, have an abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			24. Ever had problems with joints (e.g. knees, ankles)?		
12. Ever had seizures?			25. Ever had back problems?		
13. Ever had chest pain during or after exercise?			26. Any allergies to food, medication or other? Please specify:		

Date_____ Parent's Signature: _____

IMPORTANT!

PLEASE ATTACH A PASSPORT SIZE PHOTO OF YOUR CHILD TO THIS FORM.