Beatrice Mayes Institute Charter School1

Child Medical History Information

School: _____ Date: _____

Teacher: _____ Grade: _____

Please fill in this form and return it to the teacher or nurse at the earliest possible date. The information given on this form will enable the school staff to have a better understanding of the pupil's health status.

Name: _____ Gender: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone Numbers: _____

Physician's Name: _____ Number: _____

DISEASE/ MEDICAL HISTORY

	Age		Age		Age
☐Asthma	___	☐Heart Disease	___	☐Sickle Cell Disease	___
☐Allergy	___	☐Kidney Disorder	___	☐Surgery/fractures	___
☐Blood Disorder	___	☐Orthopedic	___	☐TB contact	___
☐Convulsions	___	☐Poliomyelitis	___	☐Hearing Loss	___
☐Diabetes	___	☐Rheumatic Fever	___	☐Vision Loss	___
☐Epilepsy	___	☐Serious Accident	___	☐ADD/ADHD	___

If this pupil has had any of the above conditions, did he/she receive medical care? ☐Yes ☐No
Is he/she under treatment now? ☐Yes ☐No

Please check any of the following signs and symptoms you have recently observed in pupil:

☐Tires easily	☐Frequent sore throats	☐Nail biting
☐Underweight	☐Frequent nose bleeds	☐Restlessness
☐Overweight	☐Earaches	☐Shyness
☐Frequent headaches	☐Fainting	☐Does not like school
☐Frequent colds	☐Frequent stomach aches	☐Does not get along with others

Has the pupil been seen by a physician for the above symptoms? ☐Yes ☐No
Has the pupil had a complete physical in the past year? ☐Yes ☐No

Is the pupil taking any medication?
I so, please list medication: _____.

Has this child experienced an allergic reaction to any of the following?

☐Peanuts	☐Insect bites	☐Eggs
☐Seafood	☐Milk	☐Others_____

If you checked any of the above please list the reaction experienced: _____

_____.

Has the pupil been prescribed any emergency medication for the above reaction? ☐Yes ☐No

If yes, please list the medication: _____.

PLEASE FEEL FREE TO CONSULT WITH THE SCHOOL STAFF ABOUT HEALTH PROBLEMS.

_____
Signature Date