MEDICAL RECORD

Child's Name:_____ Date of Birth:_____
Father's Name:_____Mother's Name:_____
Child's Physician_____
Siblings(name/date of birth):_____
_____
_____
_____
_____
Anyone in the immediate family seriously ill?_____
Child's Disease & Illness History:
Has your child had any of the following? Please indicate the year:

Chickenpox:_____Streptococcus:_____
Pneumonia:_____Tonsillitis:_____
Meningitis:_____Scarlet fever:_____
Heart disease or murmur:_____
Diabetes:_____Insulin:_____
Seizures:_____Medication:_____
Ears (frequent infections, tubes, hearing problems:_____
Eyes (glasses, infections, strabismus):_____
Severe allergies (please describe in detail):_____

Asthma:_____Medication:_____
Physician diagnosed hyperactivity:_____
Physical handicaps or limitations:_____
Any Surgeries (reason/date):_____
Hospitalizations (reason/date):_____
Will your child need to take medication during school hours:_____
Any other medical problem not mentioned above:_____
_____
_____
_____