



Medical and Health Insurance Information Form

Student's name _____

Medical History

Please indicate the childhood illnesses your student has had and complete the information about your child's current physical condition. **If your student has not had that illness or condition, please check the "No" box.**

Childhood illness

	Yes	No	Date
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	

Allergies

	Yes	No	Date
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Sting Reaction	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Poison Ivy, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

Current physical conditions

	Yes	No	Date
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	

Food Allergies (Please list)

Medication Allergies (Please list)

Other Allergies (Please list)

Mobility Difficulties (Please explain)

Vision Difficulties (Please explain))

Health Information (Please attach additional paper if necessary)

Has the student been under any medical care within the past three months? If so, explain.

Is there anything else we should know about your child, or any other special needs he or she may have?

In case of emergency

First contact name _____

Day phone: (_____) _____ Night phone: (_____) _____

Second contact name _____

Day phone: (_____) _____ Night phone: (_____) _____