



Beatrice Mayes Institute Charter School

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
<input type="checkbox"/> Asthma	___	<input type="checkbox"/> Heart Disease	___	<input type="checkbox"/> Sickle Cell Disease	___
<input type="checkbox"/> Allergy	___	<input type="checkbox"/> Kidney Disorder	___	<input type="checkbox"/> Surgery/fractures	___
<input type="checkbox"/> Blood Disorder	___	<input type="checkbox"/> Orthopedic	___	<input type="checkbox"/> TB contact	___
<input type="checkbox"/> Convulsions	___	<input type="checkbox"/> Poliomyelitis	___	<input type="checkbox"/> Hearing Loss	___
<input type="checkbox"/> Diabetes	___	<input type="checkbox"/> Rheumatic Fever	___	<input type="checkbox"/> Vision Loss	___
<input type="checkbox"/> Epilepsy	___	<input type="checkbox"/> Serious Accident	___	<input type="checkbox"/> 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:

<input type="checkbox"/> Tires easily	<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Nail biting
<input type="checkbox"/> Underweight	<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Overweight	<input type="checkbox"/> Earaches	<input type="checkbox"/> Shyness
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Fainting	<input type="checkbox"/> Does not like school
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Frequent stomach aches	<input type="checkbox"/> 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