



SAINT JUSTIN MARTYR

LOVE GOD. LOVE OTHERS. MAKE DISCIPLES.

MEDICAL HISTORY FORM

To be completed each school year for each student.

Student's Name: _____ Grade: _____

Vision (Eyes): Glasses _____ (reading _____ distance _____) Contacts _____
comments: _____

Hearing: frequent infections _____ tubes _____

hearing difficulty (explain) _____

hearing aid - right _____ left _____ wears at school _____

Allergies: (drugs, food, insects, pollens)

Please list: _____

Has the allergy ever required emergency action? (explain) _____

Asthma: Yes _____ No _____ Triggered by: _____

Treatments: _____

Exercise limitations: _____

Diagnosed by physician (date): _____

Seizures: Yes _____ No _____ Date of last seizure: _____

Describe seizure: _____

Medications: _____

Other medications and reason for taking: _____

Other Health Concerns:

diabetes _____ heart problems _____ blood disorder _____ eating _____ sleeping _____ bowel _____

bladder _____ bed wetting _____ menstrual history _____ phobias(fears) _____ lungs _____

skin _____ blood pressure _____ orthopedic _____ neurologic _____ TB exposure _____

sickle cell anemia _____ headaches _____

Explain: _____

Other illness, injury, or health problem that might affect performance at school: _____

Parent/Guardian: _____ Date: _____