MEDICAL HISTORY 2025-2026

(PLEASE PRINT)

Full Legal Name	Nickname
Student's name:	( )

Birthdate:_____Grade entering_____ Gender (circle one): Male Female

Child's physician:_____Physician phone:_____

Physician's address:_____

Check any of the following conditions your child has or has had and explain in detail below any current or long-term **TREATMENTS/MEDICATIONS /EDUCATIONAL ADJUSTMENTS:** *(If additional space is needed, please attach a separate sheet to this form.)*

___ Blood disorder (anemia, etc.)
___ Emotional problems (depression, anxiety, etc.)
___ Seizure disorder (epilepsy, etc.)
___ Learning difference (ADD, etc.)
___ Ear problem (deafness, mastoiditis, etc.)
___ Liver disorder
___ Kidney stones or disease
___ Tuberculosis
___ Frequent infections
___ Migraines
___ Endocrine disorder (diabetes, hypoglycemia, etc.)
___ Surgeries
___ HIV or AIDS
___ Heart problems
___ Rheumatic fever
___ Vertigo/fainting spells
___ Sinus problem

EXPLANATION:_____

_____

Any limitations/activities your child should not engage in? Please explain:_____

_____

Any social or family situations/problems of which the school should be aware?_____

_____

Long-Term Medications to Be Administered **At School**

****NOTICE: Due to our school not having a registered nurse on staff, there will be NO long term medications administered at school by school staff. If your child is on long-term medication, someone designated by a parent/guardian may come administer daily.****

Long-Term Medications Taken **At Home** (allergy, ADD, anxiety, asthma etc.)

Medication	Medical Condition	Dosage/Frequency