

**Parent**

**Medical Part I – History and Physical**

**for overnight students and students participating on a sports team**

**Health Center - School Year 2023-2024**

To be completed by parent or guardian

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student’s Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | | | Sex (M/F) |
| Address (Number, Street, City, Zip) Phone No. | | | | |
| Parent/Guardian Names | | | | |
| Where do you usually take your child for routine medical care?  Name: Address: Phone No. | | | | |
| Where do you usually take your child for dental care?  Name: Address: Phone No. | | | | |
| What other source does your child receive health care?  Name: Address: Phone No. | | | | |
| ASSESSMENT OF STUDENT HEALTH  To the best of your knowledge has your child had any problem with the following? Please check “Yes” or “No” for each of the following. | | | | |
|  | Yes | No | Comments | |
| Allergies (Food, Insects, Drugs, Latex) |  |  |  | |
| Allergies (Seasonal) |  |  |  | |
| Asthma or Breathing Problems |  |  |  | |
| Behavior or Emotional Problems |  |  |  | |
| Birth Defects |  |  |  | |
| Bleeding Problems |  |  |  | |
| Cerebral Palsy |  |  |  | |
| Dental |  |  |  | |
| Diabetes |  |  |  | |
| Ear Problems or Deafness |  |  |  | |
| Head Injury |  |  |  | |
| Heart Problems |  |  |  | |
| Hospitalization (When, Where) |  |  |  | |
| Lead Poisoning/Exposure |  |  |  | |
| Learning Problems/Disabilities |  |  |  | |
| Limits on Physical Activity |  |  |  | |
| Meningitis |  |  |  | |
| Prematurity |  |  |  | |
| Problem with Bladder |  |  |  | |
| Problem with Bowels |  |  |  | |
| Problem with Coughing |  |  |  | |
| Seizures |  |  |  | |
| Serious Allergic Reactions |  |  |  | |
| Sickle Cell Disease |  |  |  | |
| Speech Problems |  |  |  | |
| Surgery |  |  |  | |
| Other |  |  |  | |
| Does your child take any medication?  No\_\_\_\_\_ Yes \_\_\_\_\_ Name of Medication  Is your child on any special treatments? (nebulizer, epi-pen, etc.)  No\_\_\_\_\_ Yes \_\_\_\_\_ Treatment  Does your child require any special procedures? (catheterization, etc.)  No \_\_\_\_\_ Yes \_\_\_\_\_ Please Describe  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Printed Name  PB/LB/cic:4/13/23 | | | | |