



**Medical Part I – History and Physical
for overnight students and students participating on a sports team
Health Center - School Year 2026-2027**

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