STUDENT HEALTH INFORMATION

Name ________________ (Last, First, Middle)	Sex	Date of Birth

Name of school last attended:

City of school last attended:

Date of last physical exam:	Date of last dental exam:

Is your child under the care of an orthodontist?	Yes	No
Is your child under the care of an ear specialist?	Yes	No
Is your child under the care of an eye specialist?	Yes	No

If you answered yes to the above questions please specify:

Does your child have:

Allergies Yes No	Arthritis Yes No	Asthma Yes No
Bee Sting Allergy Yes No	Local Reaction Yes No	General Reaction Yes No
Bowel Problems Yes No	Cancer in any form Yes No	Diabetes Yes No
Take medicine Yes No	Require a special diet Yes No	
Ear Infections Yes No	Tubes in ears Yes No	Epilepsy or seizures Yes No
Heart Condition Yes No	Headaches Yes No	
Kidney or Bladder Problems Yes No	Leukemia Yes No	
Orthopedic problems Yes No	Tonsillitis Yes No	
Speech Problems Yes No		

If you answered yes to any above question please explain, be specific (age and dates):

Has your child had:

Bronchitis Yes No	Chickenpox Yes No	Eczema Yes No
Encephalitis Yes No	Hepatitis Yes No	Measles Yes No
Meningitis Yes No	Mumps Yes No	Pink Eye Yes No
Pneumonia Yes No	Pneumatic Fever Yes No	Scarlet Fever Yes No
Strep Throat Yes No	Tuberculosis or positive skin test Yes No	

If you answered yes to any above question please explain, be specific (age and dates):