Has your child ever had:

A serious illness?	Yes	No	If yes, please specify:
Surgery?	Yes	No	If yes, please specify:

Does your child have trouble seeing close work?	Yes	No	Date of last eye exam:
Does your child have trouble seeing at a distance?	Yes	No	
Does your child wear glasses or contacts?	Yes	No	If yes, please specify:
Does your child have trouble hearing?	Yes	No	
Does your child have a condition which prevents participation in regular physical education classes? If yes, please specify:	Yes	No	
Does your child take DAILY medications? If so, please provide a list:	Yes	No	
Does your child take EMERGENCY medications? If so, please provide a list:	Yes	No	
Does your child have any food allergies? If yes, please specify:	Yes	No	

Parent Signature: ____ Date: _______________________