

Children of The Woodlands Methodist Weekday School

Medical History Form

2010-2011 School Year

Child's Full Name _____
Last First Middle

Name Called _____ Date of Birth ____/____/____ Male____ Female____

Home Phone (____) _____

Does your child have a **chronic** illness/medical condition? yes____ no____ Please provide details:

Does your child require medication for a **chronic** illness/medical condition? yes____ no____

Include prescription/non-prescription medications: _____

Has your child been hospitalized during the last 12 months? yes____ no____ Please provide details:

Does your child have respiratory related problems? yes____ no____ Please provide details:

Has your child ever had a seizure? yes____ no____ If yes, was it related to high fever? yes____ no____

If yes, approximately how often does your child experience a seizure? _____

Is your child under a doctor's supervision to treat seizures? yes____ no____

Does your child have any vision problems? ___yes ___no

Does your child require glasses? ___yes ___no

Does your child have a hearing appliance? ___yes___no

Does your child have a history of ear problems? (Infections, tubes, decreased hearing, etc.) Please provide details:

Does your child have a dental appliance? ___yes ___no

If you have concerns about speech, vision or language problems, please explain:

If you have concerns about developmental or behavioral issues, please explain:

Is your child receiving on-going care from a therapist/professional for any reason? ___yes___no Please provide details:

Does your child have any **food allergies**? yes _____ no _____ If yes, please complete the questions in this box. Please list specific foods.

Is your child under a doctor's supervision for the food allergies? yes _____ no _____

Please give specific information about your child's food allergies, including symptoms exhibited and treatment given for the allergy (example: rash around mouth, Benadryl) _____

Does your child require a prescription epinephrine pen? yes _____ no _____

Has an Epi Pen ever been used for your child? yes _____ no _____

Date of last Epi Pen injection ___/___/___

Has your child ever been to the hospital/Minor ER for an allergic reaction? yes _____ no _____

Is your child allergic to **insect bites**? yes _____ no _____

If yes, what specific insects cause a reaction? _____

Please give specific information about your child's reaction, including symptoms exhibited _____

Does your child require a prescription epinephrine pen for reactions? yes _____ no _____

Date of last Epi Pen injection ___/___/___

Has your child ever been to the hospital/Minor ER for an allergic reaction? yes _____ no _____

Is your child allergic to latex? yes _____ no _____

Is your child allergic to **any** medications? yes _____ no _____

If yes, please list medications for emergency personnel to be aware of _____

Parent or Guardian Signature _____ **Date** ___/___/___

Please update medical information with the school nurse as necessary.

Please attach any additional medical information that you feel would be helpful to our staff or emergency medical personnel.