

# STUDENT MEDICAL HISTORY - 2021/2022

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Doctor Information: Please list all physicians your child is under the care of:

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Medical Information:

Health Insurance: \_\_\_\_\_ Health Insurance ID#: \_\_\_\_\_

List any allergies (specify: food, medication, chemical, environmental, or none)

\_\_\_\_\_

Does student need Benadryl/Epi-pen? If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Name of Dental office or clinic: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_

Does student have any ongoing illness? \_\_\_\_\_

Health Profile:

Has the student experienced:

Heart Problems	Y/N
Ear infections	Y/N
Ear tubes	Y/N
Fainting	Y/N
Kidney problems	Y/N
Hearing problems	Y/N
Vision problems	Y/N
Asthma	Y/N
Bone fractures	Y/N

Diabetes	Y/N
Seizures	Y/N
Head injury	Y/N
Concussion	Y/N
Dizziness	Y/N
Headaches	Y/N
Meningitis	Y/N
Pneumonia	Y/N
Slow/fast weight gain	Y/N
Stomachaches	Y/N
Feeding difficulties	Y/N
Sleeping difficulties	Y/N
Constipation/Diarrhea	Y/N
Coordination Problems	Y/N
Hospitalizations	Y/N
Operations	Y/N
Other Medical Procedures	Y/N

If you checked yes to any of the above, or have any medical condition not covered in any previous questions, please comment here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe your child's eating habits: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe your child's sleeping habits: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any other pertinent information you feel The Wolf School should be made aware of regarding your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_