Health Summary

(to be filled out by parent/guardian)

Name________________________________ Date of Birth______________

Allergies____

Does your child have any medical conditions? _____ If so, please explain:

____

____

____

Has your child ever had surgery? Yes ___No___ If so, at what age? What type of surgery____

Eye: Glasses/Contacts? worn Yes______ No_______

Ears: Hearing Aid Worn? Yes______ No_____

Speech: Normal? Yes_______ No_______

Does your child have any conditions which may result in an emergency?
Yes_____ No______ If yes, please explain: ________________________

____

Does your child have a condition that may limit participation in:

A. Classroom activities? Yes______ No_______
B. Physical Education? Yes______ No_______
C. Competitive sports? Yes _____ No _______

If yes, please explain____

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____

List all medications currently taking with dose and how many times a day:

____

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Any other health information that you feel the Health Office should know that would help in maintaining your child's safety and help them in the classroom?

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Signature______________________________________ Date_____________