Medford School District 549C

Student Medical History Information

School ________________
Teacher ________________
Grade ______ Gender ______
DOB ____________

____
Student Name

Please complete the following health survey. Check only the boxes that apply and that are of a significant health concern. This information will be used to develop an appropriate plan for responding to health maintenance issues and medical emergencies that may arise. All information collected is entered into the school district database and remains confidential. You are strongly encouraged to relate pertinent health concerns to your child's teacher(s) and office staff to ensure that all school district employees involved with your student are appropriately informed. Thank you for your cooperation.

Please check all of the following that apply:

	Yes	Date of Initial Onset
1. **Allergic reactions to:**		
a. Plants	☐	______
b. Foods ______________	☐	______
c. Bees	☐	______
d. Insects	☐	______
e. Animals	☐	______
f. Other ______________	☐	______
g. Allergy medications needed at home: ______________		
h. Allergy medications needed at school: ______________		
I. Describe allergic reaction: ______________		
2. **Asthma, triggered by:**		
a. Allergies	☐	______
b. Exercise	☐	______
c. Virus	☐	______
d. Other ______________	☐	______
3. **Attention Deficit Disorder**	☐	______
4. **Cancer**	☐	______
5. **Chicken Pox (month/year)**	☐	______
6. **Diabetes**	☐	______
7. **Fainting Spells**	☐	______
8. **Headaches/Migraines**	☐	______

	Yes	Date of Initial Onset
9. **Hearing Problems**		
a. Severe Hearing Loss	☐	______
b. Wears Hearing Aid(s)	☐	______
c. Ear Surgery	☐	______
d. Only with colds	☐	______
e. Other ______________	☐	______
10. **Heart Problem**		
a. Irregular Heart Rate	☐	______
b. Murmur	☐	______
c. Other ______________	☐	______
11. **Hemophilia**	☐	______
12. **Kidney/Bowel Problem**	☐	______
13. **Muscle, Bone or Joint Disease**	☐	______
14. **Premature Birth**	☐	______
15. **Seizures (not with fever)**	☐	______
16. **Vision Problems**		
a. Severe Vision Loss	☐	______
b. Eye Surgery	☐	______
c. Wears Contacts	☐	______
d. Wears Glasses	☐	______
e. Color Blindness	☐	______
17. **Other** ______________	☐	______

Please turn over...

Continued...

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____
Student Name

Please describe the cause, treatment and/or medication for all conditions marked YES:

____
____
____

List date(s) and describe major operations, injuries and hospitalizations:

____
____
____

Parent comments regarding behavior, physical or emotional problems that staff need to be aware of:

____
____
____

____________________________________ ____________________
Parent/Guardian Signature Date