MIDFIELD CITY SCHOOLS ~ STUDENT HEALTH HISTORY

Name of School: (circle one) **MES** **RMS** **MHS** School Year: 20____-20____ Grade_____

Student's Last Name First Middle Initial Date of Birth Age Sex

Street Address Home Phone #

Mother or Guardian's Name Work Phone # Cell Phone #

Father or Guardian's Name Work Phone # Cell Phone #

Emergency Contact Person Relationship Daytime Phone #

Emergency Contact Person Relationship Daytime Phone #

MEDICAL INFORMATION

Doctor's Name (Pediatrician) Clinic/Hospital Office Phone #

Doctor or Counselor's Name (Behavior Problems) Clinic/Hospital/Agency Daytime Phone #

Circle which Health Insurance your child has: Medicaid All Kids Private Insurance None

Which of the following conditions does your child have? (Check only those that have been diagnosed by a doctor!)

____ADD/ADHD ____Asthma ____ Anemia ____ Diabetes ____Epilepsy/Seizures

____Heart Problems ____Sickle Cell ____Cerebral Palsy ____Sinus Problems ____Stomach Problems

____Hearing Aid ____Nosebleeds ____Eating Problems ____Wears Glasses/Contact Lenses

____Bowel Problems ____Bladder/Kidney Problems ____Frequent Headaches ____Behavior Problems ____Sleeping Problems

____Female Problems ____Eczema/Skin ____Allergies (circle one): Food Medicine Environment

Other Medical or Behavioral conditions not listed above:_____

Medications taken at home: 1)_____ 2)_____ 3)_____

*** In the event of a critical emergency, efforts will be made to contact parent/guardian. Paramedics or EMT will be called if unable to reach a parent/guardian.

Signature of Parent/Guardian_____ Date_____