Center for Student Learning Charter School
MEDICAL HISTORY

Student's Name: ____
Last First Middle

Address: ____
Street City Zip Code

Birthdate: ________________ Grade: _____ Male:____ Female:____ Phone #: ______________________

Place a check mark in the space provided if your child has had any of the following:

	ADHD		Heart Condition		**Surgery**
	Allergies* - **Explain**		Orthopedic		Adenoids Removed
	Asthma		Psychiatric		Appendix Removed
	Bee Sting Allergy*- **Explain**		Rheumatic Fever* - **Explain**		Hernia Repair
	Chicken Pox		Seizure Disorder* - **Explain**		Tonsils Removed
	Diabetes* - **Explain**		Speech Impediment		Tubes in Ears
	Ear Infection		Tuberculosis* - **Explain**		***Other****
	Eye Glasses		Urinary		
	Hearing Loss* - **Explain**				Hospitalizations* - **Explain**

***Explain:** ____

____

Action Plans must be completed with appropriate information and signatures. See nurse for more information

Is your child currently taking medication? Yes _____ No _____
If yes, explain: ____
(See district medication policy; nurse will provide more information and required paperwork)

Is there any reason why your child can't participate in a full physical education program? Yes _____ No _____
If yes, please state reason: (*Doctor's note required*) __________________________________

____

Family History (Please circle)

Allergies
Asthma
Cancer
Diabetes
Hearing Impaired
Heart Disease
Kidney Conditions
Seizure Disorder
Tuberculosis
Visually Impaired

Explain: ____

PLEASE CHECK YOUR CHOICE OF DOCTOR OR DENTIST BELOW TO EXAMINE YOUR CHILD.

(GRADES 6, 9) FAMILY DOCTOR _____ SCHOOL DOCTOR _____
(GRADES 7) FAMILY DENTIST _____ SCHOOL DENTIST _____

STUDENTS NOT EXAMINED IN SCHOOL MUST PROVIDE THE SCHOOL WITH REPORT FROM FAMILY DOCTOR/DENTIST PRIOR TO OCTOBER 1 OR THEY WILL AUTOMATICALLY BE SCHEDULED TO SEE THE SCHOOL DOCTOR/DENTIST DURING THE SCHOOL YEAR.

HIPPA regulations require us to ask:

_____ I DO want school officials to share appropriate information regarding my child.
_____ I DO NOT want school officials to share appropriate information regarding my child.

Parent/Guardian Signature: ____ Date: ____________________