MANDATORY HEALTH HISTORY FORM

*NAME*_____ *DATE OF BIRTH*_____

ADDRESS _____, _____

*HOME PHONE #*_____ *GRADE*____ *PRIOR SCHOOL* _____

*FATHER'S NAME*_____ *BUSINESS #*_____

*MOTHER'S NAME*_____ *BUSINESS #*_____

PLEASE ANSWER ALL QUESTIONS FULLY. ANY ADDITIONAL INFORMATION MAY BE ADDED IN SPACE PROVIDED OR ON BACK OF THIS FORM.

1. *Please list any health conditions and/or disabilities your child may have:*

2. *Has your child been hospitalized in the past two years? Please explain:*

3. *Is your child presently on any medication? Please indicate name of drug and dosage.*

4. *Will your child require medication during school hours?*

5. *Does your child have any known allergies or reactions to any foods, medications, or the environment?* **PLEASE EXPLAIN**

6. *Does your child have a hearing or vision problem?*

7. *Does your child wear glasses or contact lenses?*