Health Information

(Current to 1 year or attach most recent wellness check)

Name of Child: ____

Date of Birth: ________________________ Gender: ______________

MEDICATION - List present medication(s), give dosages and times to be administered:

Name of Medication	Dosage/Time	Reason

How Does Student **Take Medications** (ex. swallows whole with water)?

____

To the best of my knowledge, this child **has / has not** (circle one) been exposed to any **COMMUNICABLE DISEASE** within the last three weeks. If so, please explain: ____

____

List significant **MEDICAL HISTORY, ILLNESSES, HOSPITALIZATIONS, &/OR SURGERIES** (give dates):

	Date		Date

Any known medical concerns, restrictions (physical or otherwise), allergies or special diet:

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Date: ________________

____
Signature of Examining Physician

____
Physician's Printed Name and Address

____

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Phone: ______________________________

Please attach copy of immunization records with this form