

LEBANON SPECIAL SCHOOL DISTRICT

MEDICAL HISTORY

CHILD'S NAME \_\_\_\_\_ SCHOOL \_\_\_\_\_

SSN# \_\_\_\_\_ HOMEROOM TEACHER \_\_\_\_\_

ADDRESS \_\_\_\_\_ GRADE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

WITH WHOM DOES YOUR CHILD LIVE? \_\_\_\_\_

MEDICAL HISTORY (CHECK WHERE APPROPRIATE)

- ASTHMA
- ADD/ADHD
- ALLERGIES \_\_\_\_\_  
(INCLUDE MEDICINE AND/OR FOOD ALLERGIES)
- DIABETES
- HEARING IMPAIRED
- HEART
- SEIZURES/CONVULSION'S
- VISION IMPAIRED (IF SO,  GLASSES OR  CONTACTS)
- OTHER \_\_\_\_\_

DOES YOUR CHILD TAKE MEDICATION? \_\_\_\_\_

\*WILL MEDICATION BE REQUIRED DURING SCHOOL HOURS? \_\_\_\_\_

NAME OF MEDICATION AND FREQUENCY? \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

SPECIAL EQUIPMENT \_\_\_\_\_

SAFETY PRECAUTIONS \_\_\_\_\_

IS THERE ANYTHING MORE ABOUT THIS CHILD'S HEALTH THAT YOU THINK IS IMPORTANT FOR US TO KNOW?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*PRESCRIBED MEDICATION GIVEN DURING SCHOOL HOURS REQUIRE ORDER FROM MEDICAL PROVIDER

\_\_\_\_\_  
**PARENT'S SIGNATURE** **DATE**