Wonderland Inc.

BEATRICE MAYES INSTITUTE
A WONDERLAND INC. SCHOOL

Child Medical History Information

Date: _____ Teacher: _____ Grade: _____

Please fill in this form and return it to the teacher or nurse at the earliest possible date. The information given on this form will enable the school staff to have a better understanding of the pupil's health status.

Name: _____ Gender: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone Numbers: _____

Physician's Name: _____ Phone Number: _____

DISEASE/ MEDICAL HISTORY

	Age		Age		Age
☐ Asthma	_____	☐ Heart Disease	_____	☐ Sickle Cell Disease	_____
☐ Allergy	_____	☐ Kidney Disorder	_____	☐ Surgery/fractures	_____
☐ Blood Disorder	_____	☐ Orthopedic	_____	☐ TB contact	_____
☐ Convulsions	_____	☐ Poliomyelitis	_____	☐ Hearing Loss	_____
☐ Diabetes	_____	☐ Rheumatic Fever	_____	☐ Vision Loss	_____
☐ Epilepsy	_____	☐ Serious Accident	_____	☐ ADD/ADHD	_____

If this pupil has had any of the above conditions, did he/she receive medical care? ☐ Yes ☐ No
Is he/she under treatment now? ☐ Yes ☐ No

Please check any of the following signs and symptoms you have recently observed in pupil:

☐ Frequent sore throats	☐ Shyness	☐ Frequent colds
☐ Frequent nose bleeds	☐ Tires easily	☐ Fainting
☐ Earaches	☐ Underweight	☐ Frequent stomach aches
☐ Nail biting	☐ Overweight	☐ Does not like school
☐ Restlessness	☐ Frequent headaches	☐ Does not get along with others

Has the pupil been seen by a physician for the above symptoms? ☐ Yes ☐ No
Has the pupil had a complete physical in the past year? ☐ Yes ☐ No
Is the pupil taking any medication? If so, please list medication: _____

Has this child experienced an allergic reaction to any of the following?

☐ Peanuts	☐ Eggs	☐ Milk
☐ Insect bites	☐ Seafood	☐ Other

If you checked any of the above please list the reaction experienced: _____

_____

Has the pupil been prescribed any emergency medication for the above reaction? ☐ Yes ☐ No

If yes, please list the medication: _____

PLEASE FEEL FREE TO CONSULT WITH THE SCHOOL STAFF ABOUT HEALTH PROBLEMS.

_____ _____

Signature *Date*