

ROCKY HILL PUBLIC SCHOOLS

Rocky Hill, Connecticut

Medical History Form

School: _____ Phone: _____
Name of Pupil: _____ Date of Birth: _____
Address: _____ Grade: _____
Family Physician: _____ Present Date: _____
Family Dentist: _____

Please answer the following questions. If "yes", please explain.

Has your child had or does he/she presently have:

	<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
<u>Any</u> communicable diseases (strept, scarlet fever, chicken pox, etc.)?	_____	_____	_____
<u>Any</u> physical deficiencies which would affect school activities?	_____	_____	_____
<u>Any</u> surgery?	_____	_____	_____
<u>Any</u> fractures or dislocations?	_____	_____	_____
<u>Any</u> vision or hearing problems?	_____	_____	_____
<u>Any</u> serious accidents?	_____	_____	_____
<u>Any</u> hospitalizations?	_____	_____	_____
<u>Any</u> allergies?	_____	_____	_____

Is your child presently:

Taking any medication on a regular basis? _____

Date of last physical examination: _____

May your child participate in all school activities without any restrictions? If "No" please explain. _____

Additional comment: _____

Signature of Parent or Guardian