

Return to Dunn School by July 15th

Required form – new students

MEDICAL HISTORY

To be completed by a parent or guardian. Please give this form careful thought and fill out entirely.

Allergies to: Medication: _____ Food: _____ Seasonal Allergies: _____

Is your child known to be resistant to any antibiotics? _____

Has student received any counseling or psychological care? Yes: _____ No: _____ If yes, when? _____

Date of last dental exam: _____ Orthodontia in progress? _____

Date of last eye exam: _____ Prescription glasses: Yes: _____ No: _____ Contacts? Yes: _____ No: _____

Please enclose copy of lens prescription (students required to wear glasses for sports must have glasses which comply with ANSI Z87.1 standard, or they will not be allowed to participate).

Is the student a vegetarian? Yes: _____ No: _____ Vegan? Yes: _____ No: _____

Dietary restrictions? Yes: _____ No: _____ If yes, explain dietary restrictions: _____

Please provide names, ages, and state of health of family members:

Parent 1: _____ Parent 2: _____

Brothers: _____ Sisters: _____

Serious illnesses or diseases occurring in family (such as TB, diabetes, heart disease, cancer, stroke, high blood pressure): _____

Important occurrences and dates in family: Deaths: _____

Divorce: _____ Adoption: _____ Other: _____

Does your child have a history of tobacco use or drug abuse? _____

Does your child have or has he/she ever had any of the following? Please circle the items that apply and comment below.

Measles	Trouble Sleeping	Gastro-Intestinal Problems
Mumps	Headaches/Migraines	Eating Disorders
Scarlet Fever	Dizziness	Deformities
Mononucleosis	Fainting	Serious Injuries
German Measles	Motion Sickness	Hernia
Chicken Pox	Allergies/Hay Fever	Bone/Joint Problems
Rheumatic Fever	Sinusitis/Bronchitis	Back Problems
Tuberculosis	Eye Problems	Foot Problems
Whooping Cough	Frequent Colds	Operations/Injuries
Diphtheria	Orthodontia	STDs
Polio	Gum/Tooth Problems	Bed Wetting
Pneumonia	Speech Problems	Kidney Problems
Ear Problems	Tonsillitis	Painful Urination/UTI
Hearing Problems	Asthma	Hepatitis
Neurological Problems	Hyperactivity	High Blood Pressure
Learning Disorder	Diabetes	Heart Problems
Depression/Anxiety	Nutritional Problems	Sleepwalking
Head Injuries/Concussions	Hypoglycemia	Skin Problems

Comments: _____

Is there anything else about your child's health that we need to know? _____

Student name: _____

Parent/Guardian's Signature: _____

2011-2012