MEDICAL HISTORY

NAME OF CHILD: **FORM COMPLETION DATE:**

Does you child have, or ever had, or is your child now taking treatment for any of the following? Check Yes, or No in the check boxes provided. Explain "Yes" answers below in the comment section.

	YES	NO		YES	NO
1.) Rheumatic Fever			9.) Backache		
2.) Asthma			10.) Joint trouble		
3.) Diabetes			11.) Major surgery or injury		
4.) Tuberculosis			12.) Severe headache		
5.) Heart disease			13.) Epilepsy		
6.) Polio			14.) Emotional problems		
7.) Chronic Respiratory			15.) Other disease or illness		
8.) High or Low Blood Pressure					

16.) Does your child have any Illness or medical condition that requires regular treatment?		
17.) Does your child have any handicap or disability that you want us to know about?		
18.) Is there any reason for restriction of your child's activity at PDO?		
19.) Does your child wear eyeglasses/contact lenses?		
20.) Does your child have any behavioral problems that we should be aware of?		

21.) List any medication (including prescriptions and over the counter medications), etc. that your child is currently taking.

22.) ALLERGIES to Medications: (Note: We do not dispense medications at PDO, however this information Is being requested in the event of an emergency)

Other Allergies:

"YES" COMMENT SECTION