

MEDICAL HISTORY

NAME OF CHILD:

FORM COMPLETION DATE:

Does your 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	<input type="checkbox"/>	<input type="checkbox"/>	9.) Backache	<input type="checkbox"/>	<input type="checkbox"/>
2.) Asthma	<input type="checkbox"/>	<input type="checkbox"/>	10.) Joint trouble	<input type="checkbox"/>	<input type="checkbox"/>
3.) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11.) Major surgery or injury	<input type="checkbox"/>	<input type="checkbox"/>
4.) Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12.) Severe headache	<input type="checkbox"/>	<input type="checkbox"/>
5.) Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	13.) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
6.) Polio	<input type="checkbox"/>	<input type="checkbox"/>	14.) Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
7.) Chronic Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	15.) Other disease or illness	<input type="checkbox"/>	<input type="checkbox"/>
8.) High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
16.) Does your child have any illness or medical condition that requires regular treatment?				<input type="checkbox"/>	<input type="checkbox"/>
17.) Does your child have any handicap or disability that you want us to know about?				<input type="checkbox"/>	<input type="checkbox"/>
18.) Is there any reason for restriction of your child's activity at PDO?				<input type="checkbox"/>	<input type="checkbox"/>
19.) Does your child wear eyeglasses/contact lenses?				<input type="checkbox"/>	<input type="checkbox"/>
20.) Does your child have any behavioral problems that we should be aware of?				<input type="checkbox"/>	<input type="checkbox"/>
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:					
<p>"YES" COMMENT SECTION</p>					