

ROCKINGHAM COUNTY PUBLIC SCHOOLS
MEDICAL FORM

COMPLETED BY THE PARENT/GUARDIAN FOR SCHOOL EVALUATION PURPOSES

Student's Name _____ School _____

Date of Birth ____/____/____ Parent/Guardian _____

Sex _____ Address _____

No. of Children in Family _____ Phone No. _____ - _____ - _____

Order of Birth _____ Family Doctor _____

In Case of Emergency Notify: (1) _____
Name Address Phone

HEALTH HISTORY

Allergies to Food, Medicine, Insect Bites or Other Yes No _____

If yes, reaction: _____ If yes, usual treatment: _____

NECESSARY EQUIPMENT

- _____ Prosthesis
- _____ Glasses
- _____ Helmet
- _____ Wheel Chair
- _____ Brace
- _____ Special Shoes
- _____ Hearing Aid
- _____ Toileting Needs

CHRONIC OR RECURRING ILLNESSES

- _____ Ear Infections
- _____ Sickle Cell Anemia
- _____ Hard of Hearing
- _____ Diabetes
- _____ Heart Disease
- _____ Asthma
- _____ Convulsions or Spells
- _____ Kidney
- _____ Rheumatic Fever

Current treatment for any of the above illnesses:

Medications taken daily: _____

Medication to be taken at school: _____

Hospitalizations/Operations (dates): _____

Recent Illnesses: _____

Special diet required: _____

Moods and behavior: _____

Comments: _____

Parent Signature

_____/_____/_____
Date