

KG Roundup Medical History Form



Student's Name _____

Birth Date _____ Sex _____ Home phone # (1) _____ ph.#(2) _____

Rev. 4-2024

MM/DD/YYYY

Parent or Guardian must complete this page, sign the form, and return the form to the school. Please mark the check box next to any condition or illness that applies to your child. Note: For medication questions, please mark the "yes" box only if child is taking medication now.	
1.	Allergy to: <input type="checkbox"/> Food: _____ Allergy to: <input type="checkbox"/> Medicine: _____ Allergy to: <input type="checkbox"/> Ants, <input type="checkbox"/> Wasps, <input type="checkbox"/> Bee stings, <input type="checkbox"/> Environmental or other. Please list: _____ Specify reaction to allergy or allergen: <input type="checkbox"/> Rash, <input type="checkbox"/> Swelling, <input type="checkbox"/> Hives, <input type="checkbox"/> Trouble Breathing, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Other _____ <input type="checkbox"/> Takes medication for any allergies. Name medication(s): _____ Does child need a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, the school will require a Diet Modification Form from a doctor. Obtain the Diet Modification Form on-line or from the School Nutrition Manager.)
2.	<input type="checkbox"/> Asthma. History of: <input type="checkbox"/> Yes Under doctor's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No List triggers: _____ <input type="checkbox"/> Takes medication for asthma. Name medication(s): _____
3.	<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD/ADHD). <input type="checkbox"/> Takes medication. Name medication(s): _____
4.	<input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Diagnosed by Medical Doctor <input type="checkbox"/> Takes medication. Name medication(s) _____
5.	<input type="checkbox"/> Autoimmune Disease (Lupus, etc.) Explain: _____
6.	<input type="checkbox"/> Blood disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Bleeding condition. Specify: _____
7.	<input type="checkbox"/> Cancer. Explain: _____
8.	<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Takes medication. Name medication(s): _____
9..	<input type="checkbox"/> Diabetes. Does child require insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No Does child require insulin <u>at school</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Takes medication. Name medication(s): _____ <input type="checkbox"/> Hypoglycemia (low blood sugar). <input type="checkbox"/> Takes medication. Name medication(s) _____
10.	<input type="checkbox"/> Digestive disorders. Explain: _____
11.	<input type="checkbox"/> Head injury (serious). Explain: _____
12.	<input type="checkbox"/> Hearing problem <input type="checkbox"/> Uses hearing aid. <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear
13.	<input type="checkbox"/> Heart condition. Explain: _____ Under doctor's care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No; Any physical restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
14.	<input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Takes medication. Name medication(s) _____
15.	<input type="checkbox"/> Kidney or bladder disorder. Explain: _____ <input type="checkbox"/> Requires catheterization. Explain or type of catheterization: _____
16.	<input type="checkbox"/> Mental Health Condition. Specify: _____ <input type="checkbox"/> Takes medication. Name medication(s) _____
17.	<input type="checkbox"/> Migraines. Under doctor's care for migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No; <input type="checkbox"/> Takes medication. Name medication(s) _____
18.	<input type="checkbox"/> Muscle/bone/mobility disorder. Explain: _____
19.	<input type="checkbox"/> Seizure Disorder. Type of seizure(s): _____ How long ago was the last one? _____ <input type="checkbox"/> Takes medication. Name medication(s) _____
20.	<input type="checkbox"/> Vision problems. Explain: _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
21.	<input type="checkbox"/> Other medical condition not listed. Explain: _____ <input type="checkbox"/> Other medications taken not listed above: _____
22.	<input type="checkbox"/> My child does <u>not</u> have any of the listed conditions or illnesses.

Additional comments or other health information:

Date: _____ Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name: _____

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