SUSSEX-WANTAGE REGIONAL SCHOOL DISTRICT

Medical History Form

Child's First Name _____ Middle Initial ____ Last Name _____

Physician's Name _____ Date of last physical: _____

Purpose of Visit:

Physician's Address _____ Routine _____

_____ Illness/Accident _____

MEDICAL HISTORY

□ No significant medical history.

Reactions to Immunizations (type?) _____

Allergies (food, medication, other) _____

Congenital defects (type?) _____

Drug sensitivities (type?) _____

Hepatitis (type?) _____

Neuro Muscular Disease (type?) _____

ADD/ADHD (type?) _____

Accidents/Injuries _____

Asthma? Year _____ Otitis Media? Year _____

Chicken Pox? Year _____ Rheumatic Fever? Year _____

Convulsive disorder? Year _____ Strep Infections? Year _____

Diabetes? Year _____ Mononucleosis? Year _____

Heart Disease? Year _____ Fractures? Year? Kind? _____

Current Medications _____

Other? Year? Describe _____

Print Name Signature Date