CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
HEALTH AND MEDICAL HISTORY FORM

TO BE COMPLETED BY PARENT:

NAME:	☐ BOY ☐ GIRL	**DATE OF BIRTH**:
HEALTH INSURANCE: ☐ NO ☐ YES	**INSURANCE CARRIER:**	

HEALTH HISTORY (COMPLETED BY PARENT): If YES, please explain:

Chronic or recurring illness/condition	No	Yes	_____
Asthma	No	Yes	_____
Diabetes	No	Yes	_____
Epilepsy/Seizures/Blackouts	No	Yes	_____
Cardiac/Heart Disease	No	Yes	_____
Hypertension	No	Yes	_____
Bleeding Disorder	No	Yes	_____
Frequent Headaches	No	Yes	_____
Skin Disorder	No	Yes	_____
Gastrointestinal Disorders	No	Yes	_____
Neuromuscular Disorder	No	Yes	_____
Orthopedic Condition	No	Yes	_____
Respiratory Illness	No	Yes	_____
Mental/Emotional Issues	No	Yes	_____
Dental/Orthodontic Appliances	No	Yes	_____
Hearing Problems	No	Yes	_____
Vision Problems (glasses or contacts)	No	Yes	_____
Hospitalizations/Surgeries	No	Yes	_____
Recent injury, illness, infectious disease	No	Yes	_____
Other _____			_____
_____			_____

OTHER SIGNIFICANT MEDICAL INFORMATION THE SCHOOL SHOULD KNOW ABOUT:

Signature of Parent: _____ Date: _____

05/2017