The Renaissance Charter Schools

Medical History Questionnaire

Medical History Questionnaire (please print clearly)

Student's Name Date of Birth

History

Has your child had any of the following?

□ Measles
□ Chicken Pox
□ German Measles (Rubella)
□ Multiple Ear Infections
□ Multiple Colds/Sore Throats
□ Seizures/Convulsions
□ Mumps
□ Other: _____

Has your child ever been hospitalized?
□ Yes □ No If yes, please explain: _____
_____
_____

Current Information

Does your child take any medication?
□Yes □ No If yes, please expalain: _____
_____
_____

Does your child have any of the following conditions? (Please check all that apply)

□ Asthma
□ Seizures
□ Headaches/Migraines
□ Diabetes
□ Urinary Problems
□ Hearing Problems
□ Vision Problems
□ ADHD
□ Allergies: _____
□ Other: _____

Does your child have any physical limitations?
□ Yes □ No If yes, please explain: _____
_____

Does your child (Please check all that apply):

□ Wear Glasses or Corrective Lenses
□ Use an Inhaler and/or Nebulizer
□ Wear Hearing Aid(s)
□ Use a Cane, Crutch or Wheelchair

Does your child have any conditions that the nurse should know about?
□ Yes □ No If yes, please explain:

_____
_____

_____
Parent or Guardian's Name (Please Print) Parent or Guardian's Signature