Metropolitan S.D.A. Jr. Academy

HEALTH REVIEW

Student's Name: _____

Grade: _____ **Teacher:** _____

Birth Date: _____ **Weight** _____

Student's Physician: _____

Address: _____

_____

Phone # : _____

Date of last physical exam: _____

Are immunizations up-to-date? **Yes** **No** **Waived**

MEDICAL HISTORY

Has the student had any allergic reactions to any drug or medicine?
Yes **No** **If yes, what?** _____

Has the student had any allergic reactions to anything else?
ie: food, bee stings, plants, etc. _____

What prescription medications has your child been on in the last 6 months?

_____

What prescription medication is your child currently taking? _____

Has your child had any of the following: (if yes, explain below)

Heart problems (murmurs, HPN, etc.)?	**No**	**Yes**
Lung problems (asthma, CP, etc.)?	**No**	**Yes**
Stomach problems (ulcer, nerves, etc.)?	**No**	**Yes**
Nervous system problems (epilepsy, etc.)?	**No**	**Yes**
Muscular and/or skeletal problems?	**No**	**Yes**
Blood disease or bleeding problems?	**No**	**Yes**
Behavior problems (ADD, etc.)?	**No**	**Yes**
Wear glasses or contact lenses	**No**	**Yes**
Any other problems, not listed?	**No**	**Yes**

_____

_____

Parent's Signature: _____ **Date:** _____