

**Metropolitan SDA Junior Academy**

**HEALTH REVIEW**

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Height: \_\_\_\_\_ 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 an allergic reaction to any medication? \_\_\_\_\_yes \_\_\_\_\_no

If yes, what medication? \_\_\_\_\_

Has the student had an allergic reaction to anything else, i.e. food, bee stings, plants?

If so, please list \_\_\_\_\_

What, if any, 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/ADHD, etc.)?	No	Yes
Wear glasses or contact lenses?	No	Yes
Any other problems not listed?	No	Yes

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Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Revised 8-1-19