Child's Medical Report

Name of Child _____ Birthdate_____

A. Medical History

1. Is the child allergic to anything? No____ Yes____

   If yes, please list here:_____

2. Is the child currently under a doctor's care? No____ Yes____

   If yes, for what reason:_____

3. Is the child on any continuous medications? No____ Yes____

   If yes, list name(s)_____

4. Any previous hospitalizations or operations? No____ Yes____

   If yes, when and what for: _____

5. Any history of significant pervious diseases or recurrent illness? No____ Yes____

   Diabetes: No____ Yes ____ Convulsions: No____ Yes ____

   Heart Trouble: No____ Yes____

   If yes, what and when:_____

6. Does the child have any physical disabilities? No____ Yes____

   If yes, please describe:_____

7. Does the child have any mental disabilities? No____ Yes____

   If yes, please describe:_____

Students will receive non-invasive health screenings pursuant to Florida Statute 381.0056. Non-invasive screenings may include vision, hearing, scoliosis, height & weight. These screenings may be given individually or in groups. Parents or guardians, however, have the right to request an exemption in writing.

Signature:_____ Date:_____