HEALTH RECORD FOR CUMULATIVE FILE

Name _____ Birthdate _____

DOES STUDENT HAVE? (yes or no)

Frequent colds_____ Frequent sore throat_____ Sinusitis_____ Bronchitis_____

Abscessed ears_____ Stomach upset_____ Kidney disease_____ Heart disease_____

Convulsions_____ Hearing deficiency_____ Vision deficiency_____ Glasses_____

ALLERGIES or Asthma_____ PLEASE GIVE SPECIFICS_____

_____

Is Student currently on medication? _____ If yes, please explain_____

_____

May Tylenol be given to student? _____

DISEASES (please indicate date)

Chicken Pox_____ Scarlet Fever_____ Rheumatic Fever_____

Measles_____ Whooping Cough_____ Mumps_____

Diphtheria_____ Polio_____ Diabetes_____

Pneumonia_____ Tuberculosis_____ Other_____

OPERATIONS (please indicate date)

Appendicitis_____ Hernia_____ Tonsils_____ Other_____

Is there any reason why the student cannot participate in a full physical education program_____ If yes,

please explain_____

Family Physician_____Phone_____

Address_____ City_____ Zip_____

_____ _____

Signature of Parent of Guardian Date