## Washington County School District 121 West Tabernacle

121 West Tabernacle Saint George. Utah 84770 (p)435-673-3553 Ext: 5138 (f)435-673-3216 www.washk12.org

## **MEDICAL HISTORY FORM**

Student's Name:		Date of Birth:		
Address:		Apt:		
City:	State:	Zip:		
Mother or Legal Guardian:	Phone: ()	Work or Cell: ()		
Father or Legal Guardian:	Phone: ()	Work or Cell: ()		
Emergency Contact:	Phone: ()	Work or Cell: ()		
Primary Care Physician:		Phone:		
□ Other (specify)  Health Care Professional		Date		
MEDICAL HISTORY				
Brief Birth History: Were there any problems during pro □ Yes □ No	egnancy or delivery of student (accider	nts, illness, infections, etc.)?		
➤ If yes, please explain:				
Were there any complications/probl □ Yes □ No	lems after birth (prematurity, oxygen, h	ospitalization, etc.)?		
Birth weight: Prem	ature? If so, how man	v weeks early?		

## **Medical Information:**

If you places syntains						
> If yes, please explain:						
pes your child receive med	dical treatments during or	outside the school o	lav (such as ovvnen d	uaetroetom		
re, special diet, tracheost				s - No		
> If yes, please explain:						
oes your child experience	frequent absences and/or	hospitalizations due	e to illness?	s 🗆 No		
➤ If yes, please explain						
oes your child have daily r	medications?			es 🗆 No		
If yes, please list:				es 🗆 No		
	medications?  What is it for?	How Much?	□ Ye	es 🗆 No		
If yes, please list:		How Much?	How often?	es - No		
If yes, please list:		How Much?	How often?	es - No		
If yes, please list:		How Much?	How often?	es - No		
If yes, please list:	What is it for?		How often? (Schedule)			
➤ If yes, please list:  Medications:  Des your child require adjuedication storage, availabi	What is it for?	school facilities (suc	How often? (Schedule)			
➤ If yes, please list:  Medications:  Dees your child require adjusted adjusted adjusted adjusted and a storage, available adjusted and a storage.	What is it for?	school facilities (sud	How often? (Schedule)			

ransportation, emergency pian, spe	cial techniques for feeding and/or positioning)	? □ Yes □ No
➤ If yes, please explain:		
oes your child have any food, med	ication, latex, or other allergies?	□ Yes □ No
If yes, please explain:		
Food or Substance	Reaction and Treatment	
	noone with their vicion and/or bearing?	 □ Yes □ No
	ncerns with their vision and/or hearing?	□ fes □ No
ii yes, piease expiairi.		
		- Vaa - Na
as your child had any hospitalization	ons or surgeries?	□ Yes □ No
If yes, please list and include d	ates:	
,, ,, , ,		
re there other things you would lik	e to tell us about your child?	
ate	Person Completing Form:	
nterview: □ Yes □ No	Position/Title:	
Vho Intorviousdu	Signatura	