Mother Teresa Memorial School

Leadership • Wisdom • Compassion • Growth

Medical History Form I Form No:_____

Date : _____

Name of the Student : _____

Age : _____ Birth date : _____ Gender : _____

Grade : _____ Section : _____

Father's Name : _____ Mother's Name : _____

Address : _____

_____

Contact No : (1) _____ (2) _____ (3) _____

Student's Doctor or Clinic : _____

Blood Group : _____ Weight : _____

PAST MEDICAL HISTORY

1. Has your child had to stay in the hospital overnight? Yes _____ No _____

   If yes, for what reason? _____

2. Check which of the following illnesses your child has had:

☐ Measles	☐ Mumps	☐ Chicken Pox
☐ Strept Throat	☐ Dehydration	☐ Bladder/Kidney Problems
☐ Ear infections	☐ Convulsion	☐ Asthma
☐ Pneumonia	☐ Bronchitis	☐ Frequent/Constant Colds
☐ Epilepsy	☐ Tonsillitis	☐ Meningitis/encephalitis
☐ Sustained high fever	☐ Allergic reaction	☐ Rashes
☐ High blood pressure	☐ Diabetes	☐ Other (explain)

3. Check if your child has had any of the following:

☐ Serious burn	☐ Auto accident
☐ Poisoning	☐ Surgery
☐ Broken bones	☐ Cuts needing doctor's care

☐ Other (explain)_____

PRESENT MEDICAL HISTORY

1. Does your child suffer from any allergy?

a. Medicine _____

b. Food _____

c. Respiratory _____

d. Skin _____

e. Any other _____

2. Does your child suffer from any chronic disease?(e.g. Asthma, diabetes, hearing disorder, epilepsy, other) if yes: _____

a. Name of Disease _____

b. Duration of Sickness _____

c. Status of the Disease - (Progressive/Regressive/Cured)

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3. Is your Child Experiencing:

Eating Problems?	Yes ☐	No ☐
Sleeping Problems?	Yes ☐	No ☐
Vision Problems?	Yes ☐	No ☐
Hearing Problems?	Yes ☐	No ☐
Activity Limitations?	Yes ☐	No ☐

4. Does your child wear glasses or lenses? Yes ☐ No ☐

if yes, is he/she supposed to wear them constantly? Yes ☐ No ☐

5. Is your child on any regular medication? Yes/no. If yes

a. Reason for taking medication _____

b. Name of medicine being taken _____

c. Dosage _____

d. Duration _____

6. When did your child last visit the doctor? _____ For what reason? _____

_____

7. I hereby declare that my ward is

a. Fit to participate in all school sports activities without any restriction. _____

b. Fit for limited participation (specify) _____

(I) Cleared for _____

(ii) Not Cleared for _____

c. Should not participate in sports. _____

Date: _____ **Parent's Sign.:** _____

(Parent or Guardian)

SCHOOL EMERGENCY MEDICAL AUTHORIZATION

If the above named pupil becomes seriously ill or injured at school and the family cannot be reached immediately for provision of instructions, I hereby authorize school personnel to call and/or arrange for transportation of the pupil to a physician.

If this physician is not available, it is understood that the school will call a doctor and/or will send the pupil, if necessary, to the nearest facility for emergency care.

It is understood, further, that I will pay for any emergency transportation and for any subsequent emergency care.

(NOTE: Parents are responsible for notifying the school about any change of information contained on this form).

Date: _____ **Parent's Sign.:** _____

(Parent or Guardian)

Please list the names of two people to be contacted in an emergency if the parents cannot be reached.

Name _____ Contact No. _____

Relation to Child _____

Name _____ Contact No. _____

Relation to Child _____