



DIVISION OF STUDENT ENGAGEMENT AND SUCCESS

Medical History Form

This Medical Form must be completed by the student or parent (if child is a minor) and the sports physical form must be completed by a physician, nurse practitioner or physician assistant.

Demographic Information

Last Name: _____ First Name: _____ Middle: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Alternate Phone: _____
 Social Security Number: _____ Date of Birth: _____ Gender: _____
 Name of Emergency Contact: _____ Telephone Number _____
 Home Phone: _____ Work: _____ Cell: _____

Student Medical History

Please check Y (yes) or N (no) for each condition.

| | Y | N | | Y | N | | Y | N | | Y | N |
|----------------------------|---|---|---------------------|---|---|----------------|---|---|-------------------|---|---|
| Allergies | | | Dizziness | | | Convulsions | | | Hernia | | |
| Bronchitis | | | Ear Infections | | | Vomiting | | | Insomnia | | |
| Head Injury | | | Excessive Fatigue | | | STD's | | | Dizziness | | |
| High or low Blood Pressure | | | Anemia | | | Anxiety | | | Malaria | | |
| Chills | | | Chest Pain | | | Meningitis | | | Heartburn | | |
| Joint Problems | | | Heart Disease | | | Epilepsy | | | Asthma | | |
| Seizures | | | Chronic Swelling | | | Frequent UTI's | | | Nervousness/Panic | | |
| Fever | | | Diabetes | | | Eczema | | | Appendectomy | | |
| Sinusitis | | | Cancer | | | Depression | | | Ulcers | | |
| Hemorrhoids | | | Tremors | | | Chronic Cough | | | | | |
| Back Pain | | | Shortness of Breath | | | Sickle Cell | | | | | |
| Paralysis | | | Thyroid | | | Arthritis | | | | | |
| Constipation | | | Chronic Colds | | | Diarrhea | | | | | |
| Nausea | | | Fainting | | | Pneumonia | | | | | |

Are you allergic to any foods, medications, or other substances? Yes ___ No ___ If yes, please list:

Student Signature _____ Date _____
 Parent Signature (if child is a minor under 18 years old) _____ Date _____