Hartland
DAY ACADEMY

MEDICAL HISTORY

(to be filled in by parent)

Blood Type:________

Student's name — Last / First / Middle

Address — Street/Box number / City / State / Zip code

Father: Mother: Insurance Policy Name & Number:

Has your child had:

- ☐ Measles ☐ Mumps ☐ Chicken pox ☐ Scarlet fever
- ☐ German Measles(rubella) ☐ Whooping cough ☐ Diphtheria ☐ Other________
- ☐ Rheumatic fever ☐ Polio ☐ Chorea(St. Vitus' dance)

Does your child have any physical problems such as:

- ☐ Diabetes ☐ Heart disease ☐ Frequent Colds
- ☐ Hypoglycemia ☐ Epilepsy ☐ Effects from serious injury or surgery
- ☐ Other: Explain____

Does your child have any allergies? ☐ Yes ☐ No Medication allergies? If yes, what are they?

Has your child ever been tested for tuberculosis? ☐ Yes ☐ No When?

Has your child had an eye examination? ☐ Yes ☐ No By whom? When?

Is your child on any kind of prescription medication? ☐ Yes ☐ No If yes, what kind?

How many hours of sleep does your child get at night?

Does your child get up easily in the morning? ☐ Yes ☐ No

Please check the boxes that best describe your child's sleep pattern.

- ☐ Sleeps soundly ☐ Awakes occasionally ☐ Regular bedtime
- ☐ Irregular and sporadic ☐ Night owl type ☐ Insomnia

Does your child participate in outdoor activities? ☐ Continuously ☐ Moderately ☐ Not at all

Does your child eat: ☐ Only at meal time ☐ Occasionally between meals ☐ Frequently

Regarding sweets and junk food:

- ☐ my child is conscientious and mostly avoids them.
- ☐ eats some, but less than most children of the same age.
- ☐ eats too much and needs to cut back.

When was the last visit to the dentist?

How often does your child brush his/her teeth? ☐ Regularly ☐ Sporadically ☐ Rarely

Month/Year

Possible physical or learning limitations?

Parent Signature ______________________ Date ______________