# Student Medical History

This form **must** be completed by a **Parent or Guardian.**

Student Name _____ DOB _____

SSN _____ Parent/Guardian _____

Parent Phone _____ Work Phone _____

Address _____ City _____ ST _____

Zip _____

Family Physician _____
Phone _____ Health Insurance Carrier _____
Policy Number _____ Group Number _____
Name of Insured _____

Does your son have any food allergies?

☐ Yes ☐ No

If yes, please list in the space below.

**Please list any/all medications (including OTC medications) your son takes.**

| **Name of Medication** | **Dosage** | **Times Given** | **Condition/Comment** |
|---|---|---|---|
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**Please indicate if your son has any of the following:**

☐ Glasses/Contacts
☐ Hearing Problems
☐ Orthodontics (currently)
☐ Skin Problems
☐ Scoliosis
☐ Surgeries
☐ Physical Problems (such as seizures)
☐ Depression
☐ Anxiety
☐ Anger Management Issues
☐ Panic Problems
☐ Phobias
☐ ADD/ADHD
☐ Learning Difficulties
☐ Sleeping Problems
☐ Eating Problems/Disorders
☐ History of Professional Counseling
☐ Need for Continued Therapy at Subiaco
☐ Diabetes
☐ High Blood Pressure
☐ Heart Problems
☐ Arthritis
☐ Asthma
☐ Restriction on Physical Activity

**If you answered yes to any of the above questions, please explain in the space below.**

**Is your son's immunization history current?** Yes ____ No ____

If no, please explain in the space below.

**Parent/Guardian Signature _____ Date _____**