



5. A. Has your child ever been treated by a psychiatrist/psychologist? If yes, please indicate inclusive dates of treatment, including names and addresses of physicians and type of treatment received.

B. Has your child ever attempted suicide? If yes, please give details.

6. Does your child have a history of illegal drug use? If yes, please give details.

7. Approximately how many days was your child absent from school during the last school year?

8. Date of last dental check _____

Dental health: excellent good fair poor

9. Has your child had any of the following (check yes or no and indicate year when applicable):

- | | | | | | |
|-----------------|--|-----------|------------------------------|--|-----------|
| Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Epilepsy or Eye Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Eye Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Ear Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Throat Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Nose Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Kidney or Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Frequent Colds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Dizziness or Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Heart Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Fracture/Broken Bones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |
| Stomach Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Year_____ |



10. Infectious disease history (check yes or no and indicate year when applicable):

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	German measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Malaria	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Infectious Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Poliomyelitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Typhoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year_____

11. Non-Prescription Medications Designation.

In caring for your children, our Medical Liaison follows general, professional medical guidelines issued by a local physician. This includes dispensing certain non-prescription medications for simple illnesses and body conditions. Sometimes parents have specific preferences with regard to these, so please indicate below your instructions for us in this matter.

You may give my child:

- A. Tylenol or Advil for pain or fever: Yes No
- B. Non-prescription cold or cough medicines: Yes No
- C. Benadryl tablets to relieve itching (for poison oak, hives, chickenpox, etc): Yes No
- D. Pepto-Bismol or other medicine for upset stomach: Yes No

12. Emergency Contact Information:

In case of an emergency, who should the school call first? Mother Father Other: _____

Mother: Home _____ Office _____ Cell _____

Father: Home _____ Office _____ Cell _____

Other: Home _____ Office _____ Cell _____



13. Insurance Information

Is your child currently covered by any form of comprehensive health, medical or accident insurance? If yes:

Name of Company _____

Address _____

City / State / Zip (Postal Code) _____ Country _____

Policy Number _____ Extent of Coverage _____

Policy Holder's Name _____

Policy Holder's Insurance ID Number _____

Policy Holder's Date of Birth _____ Relationship to Child _____

Please enclose an insurance card or photocopy of it.

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

Date