

**Pontiac Community Consolidated School District #429
Medical History Questionnaire**

Student _____ Sex _____ Birthdate _____ Grade _____

Please Explain All Questions Answered "Yes"

Yes No Premature Birth _____ Birth Weight _____

Yes No Birth Defects _____

Yes No Asthma _____ Treatment _____

Yes No Other breathing problems _____

Yes No Frequent earaches/infections _____

Yes No Known hearing problems _____ Correction _____

Yes No Known vision problems _____ Wears correction _____

Yes No Heart condition _____ Treatment _____

Yes No Diabetes _____ Date of onset _____

Yes No Seizure disorder _____

Yes No Chronic/ongoing illness _____

Yes No Serious injuries _____

Yes No Surgeries _____

Yes No Allergies (specify) _____

Yes No Restrictions in diet _____

*A doctor's order is needed every year

Yes No Restrictions in activity _____

*A doctor's order is needed every year

Yes No Does child have any other condition/disability not listed in the above categories?

Yes No Medication taken regularly (specify) _____

*Any medications taken at school need a "Request for Administration" form completed

Parent/Guardian signature _____ Date _____