MOUNTAIN MEADOW STUDENT MEDICAL HISTORY

Student Name: ______________________________ Date: ____________________

1. Physician's name, address, and telephone number:

   ____

   ____

2. Please list any current or previous health problems affecting student:

   ____

   ____

   ____

3. Does the student wear glasses or contacts? ______

   Date of last eye exam: ________________________

   Optometrist's name, address and telephone number:

   ____

   ____

4. Does the student wear dentures? ______
5. Has the student ever been hospitalized? ______

   Reason: ______________________________ Dates: ____________________

   Physician: __________________________ Hospital:

____

6. Has the student ever had surgery? ________

Reason: _____________________________________ Dates: ________________________

Physician: ________________________________ Hospital: _________________________

7. Has the student ever been involved in an accident? ________

Injuries: ____

____

8. Has the student ever broken a bone? ________

If so, which one(s): ____

____

9. Is the student allergic to any of the following?

________ Penicillin ________ Aspirin

________ Sulfa ________ Bee or wasp sting

________ Hornet or other insect ________ Shellfish

________ Iodine ________ Other _______________________

________ Any other drugs: ____

If so, what are the reactions? ____

____

Other allergies/reactions/treatment (hives, hay fever, eczema, asthma, etc.):

____

____

10. Has the student experienced any of the following? ________

________ Bed wetting ________ Stuttering

________ Nail biting ________ Head banging

________ Nightmares ________ Tics

________ Other ____

If so, at what age? ____

____

11. Please list any fears the student has had (darkness, thunder, death, etc.) and at what ages:

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12. Is the student currently on any medications? ________

Please list medications and dosage: ____

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____

(P6) 2

13. Has the student had any of the following diseases, illnesses, medical problems or disorders?

______ Anemia (low red blood count)	______ Meningitis, Encephalitis
______ Asthma	______ Mononucleosis
______ Bladder or Kidney infection	______ Mumps
______ Bone condition	______ Muscle Weakness
______ Chicken Pox	______ Pneumonia, Bronchitis
______ Convulsions or seizures	______ Polio
______ Dermatitis, eczema	______ Problems with constipation or diarrhea
______ Diabetes	______ Red measles
______ Epilepsy	______ Rheumatic Fever
______ Frequent colds/sore throats	______ Scarlet Fever
______ Frequent ear infections	______ Scoliosis
______ German Measles (3 day)	______ Ulcers
______ Heart disorder	______ Venereal disease (herpes, gonorrhea, syphilis)
______ Hepatitis	
______ High blood pressure	______ Whooping Cough (croup)

______ Other:

____

If so, please give dates:

____

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______

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______

Vaccine/Test if given as combinations (MMR or MR) enter date in each appropriate box.	Date (1st)	Date (2nd)	Date (3rd)	Date (4th)	Date (5th)
Polio (TOPV)					
DPT and/or TD (Diphtheria, Pertussis, Whooping cough and diphtheria only)					
Measles (Rubella – 10 day, red measles)					
Rubella (German Measles – 3 day measles)					
Mumps					
Tuberculosis skin test					
Tetanus					

Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student or required limitations on activities at Mountain Meadow Youth Ranch.

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This form represents the complete medical history of the student.

Parent/Guardian's Signature Date

Parent/Guardian's Signature Date