

# MEDICAL RECORD

## College Community Schools

Building: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's legal name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

If you respond "yes" to any of the following, please explain why and list date.

Yes No

		Pregnancy complications for this child:
		Prematurity: _____ How early? _____ Birth weight? _____
		Complications during or after delivery:
		Development concerns: (sitting, walking, etc.)
		Physical/Neurological disorder:
		Evaluated by medical specialist-whom? Diagnosis: Treatment:
		Medications taken regularly: _____ Dose: _____ Reason for medication:
		High Temperature resulting in seizures:
		Seizure disorder:
		Hospitalization – dates & reasons:
		Surgeries – dates & reasons
		Broken bones or other orthopedic problems:
		Concussion/head injury:
		Frequent headaches:
		Vision problems/treatment:
		Ear infections/treatment:
		Hearing problems:
		Speech/Language problems:
		Feeding/eating problems:
		Frequent stomach aches:
		Allergies/Asthma:
		Communicable diseases: _____ Had chicken pox: _____
		Evaluated by educational specialist & diagnosis:
		Requires special services or equipment:

Please add any special precautions or information the school nurse or other school personnel should know about your child.

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Signature \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Date: \_\_\_\_\_