MEDICAL HISTORY (continued)

5. Has your child received any immunizations since school ended last year? Yes [ ] No [ ]

   If yes, list name and date _____

6. Has your child been seen or treated for dental problems since school ended last year? Yes [ ] No [ ]

   If yes, list date and treatment_____

7. Does your child have a hearing problem? Yes [ ] No [ ]

   If yes, list problem_____

8. Does your child wear glasses? Yes [ ] No [ ]

   If yes, please list date of last exam by doctor _____

   Were glasses changed at that time? Yes [ ] No [ ]

   If No please list date glasses were last changed _____

9. Does your child take medicine for a **chronic** illness? Yes [ ] No [ ]

   If yes, list medicine and illness _____

   Will medicine be taken in school? Yes [ ] No [ ]

   If yes, a letter from the doctor will need to be sent to the nurse.

10. Is your child being treated for an illness at present? Yes [ ] No [ ]

    If yes, please list illness and medicine_____

11. Does your child have any health problems you are concerned about or that the school should be aware of this year?

    If yes, please list _____

12. Has your child had any emotional upsets since school ended last year? (Deaths, divorces, Separations, recent moves) Yes [ ] No [ ]

    If yes, please list_____

13. Does high blood pressure run in the family? Yes [ ] No [ ]

14. Please list the date of your child's last physical exam and name of doctor