

2009-2010 St. Boniface School Medical Information Form

Date: _____

Child's Name: _____ Grade _____

This child has had:

	At What Age
_____ Measles	_____
_____ Mumps	_____
_____ Rubella	_____
_____ Chicken pox	_____
_____ Headaches (Migraine-type)	_____
_____ Ear infections	_____
_____ Asthma	_____
_____ Epilepsy or seizure disorder	_____
_____ Allergies	_____
_____ Other	_____

Are any of the above conditions on-going? If so, please explain:

Is the child's shot record on file in the office? YES OR NO

Are there any health concerns or allergies? YES OR NO

If yes, diagnosed when? _____ By whom? _____

Please explain the problem(s) or symptoms: _____

It has been suggested that the following be done at school for my child:

Will medication(s) need to be kept at school? YES OR NO

If yes, additional paperwork is necessary.

Parent/Guardian Signature: _____

Date: _____