Student Name:_____ Age:_____ Grade:_____

School Name: **Mexico Academy and Central Schools** Date of Birth:_____ Sex:____

HEALTH HISTORY

Parent or Guardian: Does this child have a history of:

	YES	NO	If yes, give date and explanation
Chronic / Recurrent illness?			
Hospitalization?			
Surgery?			
Injuries treated by a physician?			
Current medications			
Organs missing?			
Heat exhaustion / Stroke?			
Dizziness / Fainting?			
Convulsions / Seizures?			
Headache/ Migraine?			
Concussion/ Head Injury?			
Wear glasses? Contacts?			
Hearing problems?			
Dental appliances Braces/ Bridge/ Cap/ Plate?			
Cough / Pain?			
Problems with BP / Heart / Murmurs?			
Problems with Liver, Spleen, Kidney?			
Hernia?			
Recurrent skin disease?			
Bone / Joint / Musculoskeletal injury? Sprain / Dislocation/ Fracture? Injury that caused a missed practice or event?			
Known Allergies? Food/ Medicines/ Insect Bites			Please Specify:

The above information is current and correct to the best of my knowledge.

_____ _____

Signature of Parent or Guardian Date

You have the option of having your child receive a physical exam conducted by the school's health care provider at school. If you would like the school to conduct this exam, please sign below:

I GIVE PERMISSION FOR THE MEXICO CENTRAL SCHOOL DISTRICT'S HEALTH CARE PROVIDER TO CONDUCT A PHYSICAL EXAM.

_____ _____

Signature of Parent or Guardian Date