Medical History to be completed, signed and dated by Parents and Student. Reviewed by Health Care Provider

Name of Student **Date of Birth (MM/DD/YYYY)**

Please check box if you have ever had any of the following conditions:

INFECTIOUS DISEASE
□ Chicken Pox
□ Infectious Mononucleosis
□ Rheumatic Fever
□ Scarlet Fever
□ Tuberculosis
□ Malaria

EYES, EARS, NOSE, THROAT
□ Wear Glasses/Contact
□ Other Visual Problems
□ Hearing Loss/Deafness
□ Seasonal Allergies
□ Recurrent Sinus Infection
□ Recurrent Ear Infection
□ Recurrent Nose Bleeds

CARDIOPULMONARY
□ Chest Pain with Exercise or Exertion
□ Syncope
□ Unexplained Shortness of Breath with Exercise
□ Unexplained Fatigue with Exercise
□ Heart Murmur
□ Elevated Blood Pressure
□ Mitral Valve Prolapse
□ Rheumatic Heart Disease
□ Heart Palpitations or Irregular Heartbeat
□ Elevated Cholesterol
□ Congenital Heart Defect
□ Asthma
□ Pneumonia/Bronchitis

GI
□ Reflux/GERD

□ Ulcer
□ Pancreatitis
□ Gall Bladder Disease
□ Hepatitis Type: _____
□ Hernia
□ Rectal Bleeding
□ Irritable Bowel
□ Crohn's Disease
□ Ulcerative Colitis
□ Hemorrhoids

GENITOURINARY
□ Cystitis/Bladder Infection
□ Blood in Urine
□ Kidney Infection
□ Chronic Kidney Disease
□ Kidney Stones
□ Sexually Transmitted Infection

FEMALE
□ Pelvic/Vaginal Infections
□ Pregnancy
□ Breast Lump
□ Painful Periods
□ Irregular Periods
□ Heavy Flow
□ Abnormal PAP Smear

MALE
□ Testicular Lumps
□ Testicular Torsion
□ Undescended/Absent Testicle
□ Hydrocele or Varicocele

MUSCULOSKELETAL
□ Arthritis
□ Joint Injury
□ Bone Fractures
□ Scoliosis
□ Back Pain/Problems
□ Osgood-Schlatter
□ Tendinitis

HEMATOLOGIC/ONCOLOGIC
□ Anemia
□ SickleCell Trait/Disease
□ Leukemia/Lymphoma
□ Hemophilia
□ Immune Deficiency
□ Cancer

NEUROLOGIC
□ ADD/ADHD
□ Seizure Disorder
□ Migraine Headaches
□ Tension Headaches
□ Concussion
□ Head Injury with LOC
□ Other Neurological Disorders

SKIN
□ Eczema
□ Acne
□ Hives
□ Chronic Rash
□ Tattoos/Piercings
□ Other: _____

METABOLIC
□ Diabetes Mellitus
□ Thyroid Disorder

MENTAL/EMOTIONAL
□ Anger Management
□ Eating Disorder
□ Drug/Alcohol Dependency
□ Depression
□ Panic/Anxiety Disorder
□ Trouble Sleeping
□ Bipolar Disorder
□ Mood Disorder
□ Obsessive Compulsive Disorder
□ Schizophrenia
□ Deliberate Self Harm
□ Previous Psychiatric Hospitalization
□ Other: _____

OTHER
□ Anaphylactic Reaction
□ Serious Accident/Injury
□ Surgeries:
_____
_____
_____
_____
_____

ALLERGIES: □ None or List: _____

MEDICATIONS: □ None or List: _____
(including vitamins and supplements)

Additional information you would like to share about your health:_____

_____

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for the purpose of processing this application. Undisclosed information or inaccuracies in information provided could result in dismissal from Erskine Academy.

Signature of Student: _____ Date: _____

Signature of Parent: _____ Date: _____