Subiaco Academy

Student Medical History

To be completed by Parent or Guardian

Student Name_____ Birth Date_____ SS# _____

Parent or Guardian_____ Phone_____

Work Phone_____ Cell Phone _____

Home Address_____
Street City State Zip code

Family Physician_____ Phone_____

Family Health Insurance Carrier_____

Policy Number_____ Group Number_____

Name of Insured_____

Any food or medication Allergies? Yes No

If yes, please list _____

_____

Immunization current	Yes	No	Phobias	Yes	No
Glasses	Yes	No	ADD/ADHD	Yes	No
Contacts	Yes	No	Learning Difficulties	Yes	No
Hearing problems	Yes	No	Sleeping Problems	Yes	No
Orthodontics presently	Yes	No	Eating problems or disorders	Yes	No
Skin problems	Yes	No	History of or current professional counseling	Yes	No
Scoliosis	Yes	No	Need for continued therapy while at Subiaco Academy	Yes	No
Surgeries	Yes	No	Diabetes	Yes	No
Physical problems such as seizure	Yes	No	High blood pressure	Yes	No
Depression	Yes	No	Heart problems	Yes	No
Anxiety	Yes	No	Arthritis	Yes	No
Anger Management problem	Yes	No	Asthma	Yes	No
Panic problem	Yes	No	Restriction on physical activities	Yes	No

Please Initial _____

Please list all medications and any over the counter medications your son takes.

Name of Medication	Dosage	Times Given	Condition/Comment

Please explain any yes answered about your son's health.

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Signature _____

Date _____