WEYMOUTH PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Dear Parent/Guardian:

Please complete the following questionnaire which will help us to complete your child's medical history.

1. Does your child have any allergies? Please include food allergies.

_____
_____

2. Does your child have any allergy to bee stings or other insect bites? If yes, please include individual symptoms of a reaction.

_____
_____

3. Does your child have a history of asthma or a tendency to be bronchial?

_____
_____

4. Does your child have any eye or ear condition?

_____
_____

5. Does your child have a history of convulsions or seizure disorders?

_____
_____

6. Does your child have a history of kidney or heart conditions?

_____
_____

7. Does your child have any orthopedic condition? If yes, does the condition restrict him/her in physical education or school activities?

_____
_____

8. Does your child have other medical history of which we should be aware?

_____
_____

9. Does your child take any prescribed medication routinely? If yes, please explain.

_____
_____

Student's Name_____
(please print)

Parent / Guardian Signature_____ **Date**_____

Revised 2002