BFS STUDENT MEDICAL HISTORY FORM

STUDENT'S NAME (Last. First, Middle Initial)	DATE OF BIRTH	MALE ( ) FEMALE ( )	GRADE
FATHER'S NAME (Last, First, Middle Initial)	COMPANY / ORGANIZATION	OFFICE PHONE	EMERGENCY INFORMATION NAME
HOME ADDRESS		HOME PHONE	PHONE
BLOOD TYPE	CURRENT MEDICAL PROBLEMS	CURRENT MEDICATIONS	

PAST MEDICAL HISTORY (Please include year & age)

Date/Age	Illness	Date / Age	Illness	Allergies	Fractures	Date	Operations	Date	Other
	Chicken Pox		Convulsions						
	Measles		Meningitis						
	Rubella		Hepatitis						
	Mumps		Rheumatic Fever						
	Whooping cough		Pneumonia						
	Poliomyelities		Tuberculosis						
	Substance Abuse								

IMMUNIZATION RECORD

DATES FOR IMMUNIZATIONS	DPT	OPV	MMR	TB SKIN TEST (IPPD)	DT BOOSTER	OTHER

VISION PROBLEMS	PERMISSION IS GRANTED FOR:	PARENTS OR GUARDIAN'S SIGNATURE	DATE
	( ) Tylenol ( ) Ibuprofen ( ) Decongestant / Antihistamine ( ) Throat lozenges ( ) Couth Syrup ( ) Peptobismol ( ) Treatment of illness ( ) Emergency care		
HEARING PROBLEMS			

SCHOOL SCREENING RECORD

DATE	GRADE	HEIGHT(inches)	WEIGHT (ibs)	R VISION L	COMMENTS