Hanover Schools
MEDICAL HISTORY FORM

Student Name	Student Address	Date of Birth

Please list any health concerns or pertinent information which you think would be helpful for the school nurse to know.
If you would prefer to discuss privately, please contact the school nurse.

If your child has a history of asthma, please fill out the asthma questionnaire.

Has your child ever had a serious illness/hospitalization/surgery/seizure disorder? *If yes, please explain.*	**YES**	**NO**
Does your child take medicine at home on a regular basis? *If yes, please explain.*	**YES**	**NO**

If your child will need medication in school, please obtain a medication consent/doctor order form and return it to the school nurse.

Please list any allergies?

If your child has an EpiPen, please obtain an EpiPen medication consent/doctor order form and return it to the school nurse.

Does your child have any visual difficulties? *If yes, please explain.*	**YES**	**NO**
Does your child wear glasses? If yes, please answer the following:	**YES**	**NO**
☐ All the time? ☐ Distance only? ☐ Reading only?		

Vision Specialist

Name of Vision Specialist	
Address	Phone Number

Does your child have any hearing difficulties? If yes, please explain.	**YES**	**NO**
Does your child have ear tubes? If yes, please answer the following:	**YES**	**NO**
☐ Both ears? ☐ Right ear only? ☐ Left ear only?		

Ear Specialist

Name of Ear Specialist	
Address	Phone Number

Is your child able to participate fully in physical education or school sports program?	**YES**	**NO**

Physician Information

Name of Physician		
Address	Phone Number	Date of Last Exam

Dentist Information

Name of Dentist		
Address	Phone Number	Date of Last Exam

Parent/Guardian Signature	**Date**