

Medical History Form for Students

Student Information:

- Name: _____
- Date of Birth: _____
- Grade: _____
- School Name: _____
- Parent/Guardian Name: _____

Medical History:

1. Current Medications:

- _____
- _____

2. Allergies:

- _____
- _____

3. Previous Illnesses:

- _____
- _____

4. Surgeries or Hospitalizations:

- _____
- _____

5. Family Health History:

- _____
- _____

Emergency Contact:

- Name: _____
- Relationship: _____

- **Contact Number:** _____

Parent/Guardian Signature: _____

Date: _____