INTERNATIONAL SCHOOL OF LATVIA

*** To be filled out by **PARENTS** ***

MEDICAL HISTORY FORM

Student Name: _____ **Grade:** _____

1. CURRENT MEDICAL HISTORY – Please check which health problems your child currently has:

	YES	NO	DESCRIBE
Allergy			If **yes**, also fill out the *Allergy Form*
Anemia			
Asthma			If **yes**, also fill out the *Asthma Form*
Diabetes			If **yes**, also fill out the *Diabetes Form*
Emotional issues (anxiety, depression)			
Headaches			
Heart problem			
Hearing problem			
Learning disability (dyslexia, ADHD, autism)			
Nosebleeds			
Seizure disorder (epilepsy)			If **yes**, fill out the *Seizure Disorder Form*
Special diet			
Speech problem			
Vision problem			
Other:			

2. Does your child take any medications? [ ] YES [ ] NO

How often? [ ] every day [ ] only when needed

Please list all medications below:

Name of medication	Dosage & when taken

3. Does your child need medicine to be given by the School Nurse during the school day? [ ] YES [ ] NO

If **YES**, please see the School Nurse.

4. PAST MEDICAL HISTORY - Please check off which health problems your child has had:

	YES	NO	Please describe
Chicken Pox *(varicella)*			
Previous surgeries/operations			
Serious Illnesses / Injuries			
Past Concussion (head injury)			

	YES	NO
Are there any restrictions on your child's participation in school activities?		
I agree that First Aid may be provided to my child by the School Nurse or other trained personnel.		
I agree that important medical information may be shared with ISL staff members and coaches if needed to best support your child.		

Parent/Guardian Signature: _____ ***Date:*** _____