ESSEX REGIONAL EDUCATIONAL SERVICES COMMISSION

Essex Junior Academy, Essex High School, Essex Campus Academy

Name_____ Gender____ Date of Birth_____

School of Attendance_____ Grade_____

Health History

Important Medical History _____

_____

_____

Allergies No_____ Yes_____ Explain _____
Type of reaction_____ Treatment/Medication_____

_____

Asthma No _____ Yes _____ Medication/Inhaler _____

Please complete the medication forms for your child's asthma medication administration.

Seizures/Convulsion No ___ Yes _____ Medication_____

Diabetes No_____ Yes_____ Medication_____

Is your child on any Medication No_____ Yes _____ Medication _____

Hospitalizations No _____ Yes _____ Reason _____

_____

Fractures/Broken bones/or Serious Injuries No____ Yes___ Explain_____

_____

Other health conditions _____

_____

Can you child take gym No ____ Yes ____Does your child wear eyeglasses No____ Yes_____

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____

Phone number_____ Date _____