



Winchester Academy Medial Information Form

Home of the Eagles

Child's Name _____

1. Has your child been treated for a serious health condition? Yes No
2. Does your child have any allergies?(food, medicines, seasonal) Yes No
3. Does you child take any medications?(over the counter or prescription) Yes No
4. Will your child require us to administer medication at school? Yes No
5. Does your child have a chronic medical condition? (Ex: asthma, diabetes, seizure disorder, ADD, ADHD, depression etc.) Yes No

If you answered YES to any of the above questions please provide further explanation. _____

Past Childhood Medical History(check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other(explain) | <input type="checkbox"/> Surgeries(list) | <input type="checkbox"/> RSV | <input type="checkbox"/> Impetigo |
| _____ | _____ | <input type="checkbox"/> Ringworm(Fungus) | |
| _____ | _____ | | |

Current Medical History(check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Vision Deficit | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Heat Exhaustion |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Freq.Nosebleeds | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Dental Issues | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Gluten | <input type="checkbox"/> Other | | |

Current Medications(even if taken at home!)

- | | |
|------------|--|
| Medication | Will this need to be taken at school? |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Winchester Academy

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