

**Student Medical Profile**

Name \_\_\_\_\_

(Have you ever had or have now: (Please check at the right of each item and if yes, indicate year of first occurrence.

Condition	Y	N	Year	Condition	Y	N	Year
Rheumatic fever				Epilepsy/fits/seizures			
Heart problems				Anxiety			
Shortness of breath				Stomach upsets/ulcer			
Asthma				Frequent vomiting			
Pneumonia				Gall bladder trouble			
Chronic cough				Jaunice or hepatitis			
Tumor of skin disease				Rectal disease			
Sexually Transmitted Disease				Abdominal pain			
Hay fever				Hernia			
Arthritis				Excessive tiredness			
Concussion				Eye problems/poor eyesight/color blindness			
Severe headache/Migraine				Skeletal deformity			
Depression				Shoulder dislocation			
Dizziness or fainting spells				Knee problems			
Severe head injury				Back problems			
Paralysis				Neck injury			
Diabetes				Broken bones			
Menstrual problems				Kidney problems			
Phobias				Hearing loss			
Behavior problems				Allergy to drugs/animals/food			
Current medications (state)				Previous surgery			

**Vaccinations and Immunizations**

Vaccination	Y	N	Not Sure	Date	Vaccination	Y	N	Not Sure	Date
<b>Triple Antigen</b> (Diphtheria/Tetanus /Pertussis or whooping cough when young baby)					<b>Sabin Oral Polio Vaccine</b> (4 doses)				
<b>Tetanus Toxoid</b> (Given in Grade 1 and Grade 6)					<b>Hepatitis B</b>				