# HELLENIC COMMUNITY SCHOOL
## MEDICAL HISTORY 2009 - 2010

**PLEASE PRINT**

Students Name: _____ _____
Surname Given Name

Date Of Birth: _____
(Day) (Month) (Year)

Address: _____

_____ Phone #: _____

Mother/Guardian: _____ Home # : _____
Work # : _____
Cell #: _____

Father/Guardian: _____ Home # : _____
Work # : _____
Cell #: _____

**Student Medical Information:**

Health Care Number: _____

Additional Medical/Hospital Coverage Policy Number: _____

Family Doctor: _____ Phone #: _____

**Please check if he/she is subject to any of the following conditions:**

☐ Arthritis ☐ Asthma ☐ Bronchitis
☐ Hay Fever ☐ Heart Disease ☐ Migraine Headaches
☐ Menstrual Difficulties ☐ Diabetes ☐ Hernia
☐ Kidney Disease ☐ Lactose Intolerant ☐ Epilepsy
☐ Ear Problems ☐ Nose Bleeds ☐ Mononucleosis
☐ Tendonitis/Soft Tissue Injury

Other: _____

How do you usually treat these conditions? _____

_____

_____

Chronic conditions, recent illness or surgery of which the staff should be aware of:

_____

_____