MORRISTOWN SCHOOL DISTRICT #75
25950 West Rockaway Hills Drive
P.O. Box 98
Morristown, Arizona 85342
623-546-5100

Name:____ Grade: __________ DOB:______________.
(Last, First, Middle Initial) (MM/DD/YY)

Emergency Contact: ____ Phone____________________
Emergency Contact: ____ Phone____________________

Has the child ever had any of the following? If "yes," please give the age or year at the time.

Select		Condition	Age/Year	Select		Condition	Age/Year
○Yes	○No	Arthritis	________	○Yes	○No	Heart Condition	________
○Yes	○No	Allergies	________	○Yes	○No	Hepatitis	________
○Yes	○No	Asthma	________	○Yes	○No	High Blood Pressure	________
○Yes	○No	Bronchitis/Pneumonia	________	○Yes	○No	Kidney Disease	________
○Yes	○No	Chicken Pox	________	○Yes	○No	Scoliosis	________
○Yes	○No	Cystic Fibrosis	________	○Yes	○No	Eczema	________
○Yes	○No	Diabetes	________	○Yes	○No	Epilepsy/Seizures	________
○Yes	○No	Frequent Ear Infections	________	○Yes	○No	Strep/Tonsillitis	________
○Yes	○No	Sinusitis	________	○Yes	○No	Urinary Track Infections	________
○Yes	○No	Skin Rash	________	○Yes	○No	Other Condition	________
○Yes	○No	Stomach Problems	________				
○Yes	○No	Tuberculosis	________				

○Yes ○No Is your child currently receiving treatment for any physical condition?
○Yes ○No Is your child currently taking any medicine?
○Yes ○No Has your child ever had a psychological examination?
○Yes ○No Has your child ever had speech, vision, or hearing difficulties?
○Yes ○No Does your child use glasses or contact lenses?
○Yes ○No Does your child have hearing loss or wear hearing aids?
○Yes ○No Does your child have any significant behaviors that may affect their ability to perform it school?

Please explain and "Yes" answers: ____
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Parent/Guardian Signature____ **Date**____________