DESERT VIEW
CHRISTIAN SCHOOL
2425 American Legion Blvd Mountain Home, ID
(208) 580-0512

Medical History

Student Name _____ Grade _____

Does your child have any current medical conditions? Yes☐ No☐
If Yes, please list:

_____

_____

Does your child have any allergies (Medication, food, or other)? Yes☐ No☐
If Yes, please list:

_____

_____

Does your child have Asthma? Yes ☐ No ☐
If Yes, What are your child's specific symptoms or signs of the attack?

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What triggers or causes the attack?

_____

_____

What treatments help your child in the event of an attack? Include any effective calming techniques, medications, and when to contact a parent or doctor.

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Is your child taking any medications at this time? Yes ☐ No ☐
If Yes, please list the name of the medication, the dosage, when the child takes the medication, and reason for taking the medication. If there are any changes to this information during the school year, please notify the teacher or School Board Chair.

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☐ None of the above listed conditions apply to my child.

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Parent/Guardian Signature Date