PIN OAK MIDDLE SCHOOL
PHYSICAL EDUCATION DEPARTMENT
MEDICAL INVENTORY

Student's Name:_________________________________ Gender:______ DOB:__________ House:______
Last, First M.

Home Address:____ City:_____________ Zip Code:________

Mother's Name:____________________________________ Cell #:____________________

Email address:____________________________________

Father's Name:____________________________________ Cell #:____________________

Email address:____________________________________

MEDICAL HISTORY
(Check all that apply)

___asthma
___allergies
___blood disorder
___convulsions
___diabetes
___epilepsy
___heart disease
___kidney disorder
___orthopedic
___rheumatic fever
___serious accident
___sickle cell disease
___surgery/fractures
___earaches
___fainting
___frequent nose bleeds
___overweight (diagnosed by dr)
___eating disorder

If this student has had any of the above conditions, did he/she receive medical care? ___yes ___no

Is this student under treatment now? ___yes ___no

Is this student on any kind of medication? ___yes ___no

If so, please list medication(s):____

____

For what condition?____

Has this student had a complete physical in the past year? ___yes ___no

Other Important Information:____

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____ _________________________
Parent Signature Date