

# Citrus Park Christian School

## MEDICAL HISTORY

PLEASE PRINT

NAME \_\_\_\_\_  
LAST
FIRST
MIDDLE INITIAL

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Do you have or have you ever had any of the following? (Please check EACH of the following Yes or NO. Any Yes answer must be fully explained below.) Answer ALL questions.

	Yes	No		Yes	No
Epilepsy	<input type="radio"/>	<input type="radio"/>	Psychiatric or Psychological Treatment or Evaluation	<input type="radio"/>	<input type="radio"/>
Diabetes (Sugar Problems)	<input type="radio"/>	<input type="radio"/>	Hemophilia or other blood disease	<input type="radio"/>	<input type="radio"/>
Cardiac (Heart) Disease	<input type="radio"/>	<input type="radio"/>	Osteomyelitis	<input type="radio"/>	<input type="radio"/>
Marie Strumpell Disease	<input type="radio"/>	<input type="radio"/>	Stiff Joints	<input type="radio"/>	<input type="radio"/>
Any Loss of Vision	<input type="radio"/>	<input type="radio"/>	Hypoglycemia (Sugar Problems)	<input type="radio"/>	<input type="radio"/>
Polio	<input type="radio"/>	<input type="radio"/>	Muscular Dystrophy	<input type="radio"/>	<input type="radio"/>
Any Amputation	<input type="radio"/>	<input type="radio"/>	Thrombophlebitis	<input type="radio"/>	<input type="radio"/>
Cerebral Palsy	<input type="radio"/>	<input type="radio"/>	Hemiated Intervertebral Disc	<input type="radio"/>	<input type="radio"/>
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	Back Surgery	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>
Vascular (Circulation) Disorder	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>

Have you ever received treatment for a back, neck or knee condition or head injury? \_\_\_\_\_

Do you now or have you ever suffered from aches or pains of the back? \_\_\_\_\_

Have you ever had any surgery? \_\_\_\_\_

Do you now or have you ever had any physical disabilities, impairments or handicaps? \_\_\_\_\_

Have you ever had a workers' compensation injury? \_\_\_\_\_

Have you every received a disability rating for any reason? \_\_\_\_\_

Have you ever received compensation or medical benefits under workers' compensation? \_\_\_\_\_

Explain fully any Yes answer: (Use other side of page if necessary.) \_\_\_\_\_

\_\_\_\_\_

I have been fully advised that if I am injured on the job, regardless of how minor the injury may seem, I am to report that injury immediately to my supervisor. Yes  No

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and basis for termination of employment. I also understand that my answers will be verified by investigation.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_