Seneca Falls Central School District
Medical History

Student's Name _____Date of Birth _____ Grade _____
Parent/Guardian Name(s) _____
Home Address _____ Phone _____
Physician's Name _____Phone _____

Medical History: Does your child have or has he/she had any of the following:

____ Chickenpox	____ Pneumonia	____ Meningitis
____ Diphtheria	____ Rheumatic Fever	____ Encephalitis
____ German measles	____ Scarlet Fever	____ Tuberculosis or contact with
____ Measles	____ Diabetes	____ Bowel Problems
____ Mumps	____ Epilepsy	____ Kidney Problems
____ Whooping Cough	____ Heart Disease	

Does your child have?

Asthma Yes ____ No ____
If yes, please describe what triggers an attack, how often attacks are, and what treatment is given:
_____
_____

Seizures Yes ____ No ____
If yes, please describe how often, how long they last, and what treatment is used:
_____
_____

Frequent earaches or ear infections Yes ____ No ____
Frequent sore throat or strep throat Yes ____ No ____
Hyperactivity/Attention Deficit Disorder Yes ____ No ____
If yes, please describe how it is being treated:
_____

Allergies Yes ____ No ____
If yes, please mark what type of allergy
____Food (what food) _____
____Bees
____Medication (name/type of medication) _____
____Seasonal/Environmental_____
What reaction does your child have to the allergy? _____
What treatment is required for this allergy? _____
Does your child take any medication during school hours? Yes ____ No ____
If yes, name of medication and dosage? _____
_____

You must supply the school with a written statement from the doctor for #7
<u>Has your child ever had?</u>
A serious head injury Yes ____ No ____
If yes, please describe the injury, when it happened, treatment, and any lasting effect on student:
_____

Lead poisoning Yes ____ No ____
If yes, when and how was it treated?
_____

A serious injury or accident Yes ____ No ____
If yes, please describe and give date

_____

An operation Yes ____ No ____
If yes, please describe and give date

_____

Been hospitalized Yes ____ No ____
If yes, for what reason and when?

_____

Any problem with eyes or eyesight Yes ____ No ____
If yes, has he/she been seen by an eye examiner? Yes ____ No ____
If yes, please give date and results of exam and treatment recommended

_____

Any problem with ears or hearing Yes ____ No ____
If yes, has he/she had a hearing test or evaluation? Yes ____ No ____
If yes, please give date and results of exam and treatment recommended

_____

Speech or language problem Yes ____ No ____
If yes, was a speech or language evaluation done? Yes ____ No ____
If yes, please give date and results of evaluation and recommendation

_____

Other medical problems not previously listed_____

_____

Does your child have any physical disabilities that would limit his/her involvement in physical education class?
Yes ____ No ____ If yes, please describe _____

_____

You will need to send a doctor's statement to school if your child cannot fully participate in physical education class.
Any other problems or concerns you would like the school nurse to be aware of? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature _____ Date _____