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.)**
____
____

<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 ____________________

ADA Compliant