

**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:**

<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> German measles	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis or contact with
<input type="checkbox"/> Measles	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bowel Problems
<input type="checkbox"/> Mumps	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> 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**

**Has your child ever had?**

**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? \_\_\_\_\_

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_