WHITE PLAINS CITY SCHOOL DISTRICT
FAMILY INFORMATION CENTER
500 North Street
White Plains, NY 10605
(914) 422-2038

MEDICAL HISTORY

Student's Name:		DOB:	
Home Address:		Tel Number:	
Pediatrician's Name:		Tel Number:	
Dentist's Name:		Tel Number:	

PAST AND PRESENT ILLNESSES: Has your child had any of the following conditions? (Yes/No)

Condition	Yes	No	Condition	Yes	No
Allergies			Headaches (frequent)		
Anemia			Heart Disease		
Asthma			High Blood pressure		
Cancer			Immunodeficiency		
Diabetes			Mental illness		
Ear Infections (frequent)			Seizure Disorder		
Emotional Disability			Skin Rashes		
Fainting			Positive Tuberculin Test		
Other:					

If you answered "Yes," to any of the above, please explain:

Does your child take medication? _____ Name: _____
For what reason? _____
Has your child had a serious injury or illness that required hospitalization? _____ If "yes," please explain.

Does your child have poor vision? Left Eye? _____ Right Eye? _____ Wears glasses? _____
Does your child have poor hearing? Left Ear? _____ Right Ear?

Parents should DIRECTLY inform the school nurse if their child has a life-threatening allergy or illness to ensure their safety in school.

Please check only ONE appropriate statement below.

_____ I **DO** give the nurse permission to share information, if necessary, with teachers and staff associated with my child's educational experience.

_____ I **DO NOT** give the nurse permission to share information, if necessary, with teachers and staff associated with my child's educational experience.

Name of Parent/Legal Guardian Signature of Parent or Legal Guardian Date

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ALLERGY FORM

ALLERGIES: Please detail below.

At what age was your child diagnosed with an allergy? _____

Which physician made this diagnosis? Pediatrician/Allergist?_____

Name of current physician? _____ Number?_____

Address: _____

What symptoms led to this diagnosis:_____

_____

Parents should DIRECTLY inform the school nurse if their child has a life-threatening allergy or illness to ensure their safety in school.

Has your child had any of the following?

Skin testing for allergies?	Yes		No	
Blood testing?	Yes		No	
A food challenge?	Yes		No	

Is your child currently taking any medication?	Yes		No		
Name	**Dose**				**Frequency**

How many allergic reactions has your child experienced?
Has an Epi Pen ever been administered to your child?
Has your child ever been hospitalized for an allergic reaction?
Is your child aware of his/her allergies?
Has your child had a reaction at camp?
Do you have any issues or concerns that you would like to share with the nurse?
Does your child have an Epi Pen prescribed for him/her?

Name of Parent/Legal Guardian Signature of Parent or Legal Guardian Date