WHITE PLAINS CITY SCHOOL DISTRICT
FAMILY INFORMATION CENTER
350 Main Street
White Plains, NY 10601
(914) 422-2038

MEDICAL HISTORY FORM

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