Pittsford Central School District

Student Health Information Form

To be completed by parent or guardian and returned to the School Health Office

Child's Name _____ Birthdate _____ Grade _____
Physician's Name _____ Phone _____
Dentist's Name _____ Phone _____

Health History (check all that apply and explain below)

☐ ADD/ADHD	☐ Chicken Pox	☐ Heart Condition	☐ Scoliosis
☐ Anemia	☐ Dental Injuries	☐ Hernia Repair	☐ Seizure Disorder
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Single Organ
☐ Asthma /trouble breathing	☐ Ear Infections	☐ Mental Health/Psych Issue (depression, eating disorder anxiety, OCD, ODD, etc.)	☐ Skin Condition
☐ Autism/Asperger's/etc.	☐ Gastrointestinal Condition (ulcer, reflux, IBS, etc.)		☐ Speech Condition
☐ Bleeding Disorder			☐ Urinary/Kidney Problem
☐ Cancer	☐ Headaches/Migraines	☐ Orthopedic Condition	
☐ Vision Deficit ☐ Wears Glasses ☐ Contacts		☐ Hearing Deficit ☐ Hearing Aid ☐ Cochlear Implant	
☐ Allergies (specify type of allergy: environmental, food, insects, latex, medication and previous reactions)			
☐ Congenital Condition			
☐ Concussion with or without loss of consciousness (list dates injury occurred)			

Please list any hospitalizations or surgeries:

_____

Please list any injuries requiring medical care:

_____

Does your child receive treatments or use assistive equipment during or outside the school day?

☐ Insulin/blood glucose monitoring ☐ Inhaler/nebulizer/peak flow monitoring ☐ Special diet
☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other _____

Does your child take medication either at home or at school? (list name, dose, and time(s) of administration)

_____

_____

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes _____

Additional Information: _____

_____

_____

Completed by: _____ Date: _____
Please Return to: