



BEDFORD CENTRAL SCHOOL DISTRICT

632 South Bedford Rd • Bedford, NY 10506

914-241-6000 • www.bcsdny.org

Inspiring and Challenging Our Students

Dr. Robert Glass, *Superintendent of Schools*

Dr. Louis Corsaro, *Medical Director*

Health History

Name of Student _____

☐ Male ☐ Female Grade _____ Date of Birth _____

The School Health Services will gladly cooperate with you if your child has any health issues that might affect his/her education. Please update the following questions in order to help us in planning for a positive educational experience for your child.

1. History of serious illness or operations: _____

2. History of asthma/allergies: _____

3. Is your child currently receiving any medical treatment? _____

4. Is your child currently on any medications? ☐ Yes ☐ No

If yes, please list medication(s) _____

5. Does your child wear glasses? ☐ Yes ☐ No

Does your child wear contact lenses? ☐ Yes ☐ No

If yes, under what conditions does he/she wear them? _____

6. Does your child have a hearing difficulty? ☐ Yes ☐ No

If yes, please describe _____

7. Should your child be restricted from physical activity? ☐ Yes ☐ No

If yes, please describe _____

8. Are there any special health needs you wish to bring to our attention such as problems of behavior, growth, or nutrition? _____

Please check the appropriate box:

- ☐ I give permission to the nurse to share this information with teachers and staff associated with my child's educational experience.
- ☐ I do not give permission to the nurse to share this information with teachers and staff associated with my child's educational experience.

Signature of Parent/Guardian _____