NORTH MERRICK UNION FREE SCHOOL DISTRICT
HEALTH RECORD

TO BE COMPLETED BY PARENT/GUARDIAN

Student Information		
Last name:	First name:	Date of Birth:
Sex:		
Birthplace:		
Address:		
Phone Number:		

Parent / Guardian & Healthcare Providers
Mother's Full Name
Father's Full Name
Dentist's Name, Address, Telephone Number
Physician's Name, Address, Telephone Number

MEDICAL HISTORY

Health Questions	**Yes**	**No**
Chicken pox (specify with date)	☐	☐
Defective vision/hearing	☐	☐
Seizure disorder	☐	☐
Medical problems immediately after birth	☐	☐
Diabetes	☐	☐
Medication (on a regular basis)	☐	☐
Heart defect	☐	☐
Orthopedic problems	☐	☐
Operations	☐	☐
Any other physical problem	☐	☐
Serious illness/injury	☐	☐
Psychological therapy/testing	☐	☐
Asthma	☐	☐

	Yes	No
*Allergies (If yes, please specify below.)	☐	☐
Speech therapy/testing	☐	☐
Chronic ear infection (more than two years)	☐	☐
Does child have an unusually short attention span?	☐	☐
Is child dealing with family stress (illness, death, separation)?	☐	☐
Restriction of physical activity	☐	☐

If the answer to any question above is YES, please indicate the age of occurrence and provide specific details:

Parent Signature	Date