

FONDA-FULTONVILLE CENTRAL SCHOOL HEALTH HISTORY

NAME _____ MALE/ FEMALE _____ GRADE _____
DATE OF BIRTH _____ PLACE OF BIRTH _____

MEDICAL HISTORY - If your child has had or currently has any of the following please provide specific information with dates:

Allergies _____ Bee Sting Allergy _____ Reaction: _____
Asthma _____ Food Allergy _____ Reaction: _____
Chicken Pox _____ Rheumatic Fever _____
Ear Conditions _____ Frequent/Chronic Headaches _____
Seizure Disorder _____ Head Injury _____
Orthopedic (Bone & Joint) _____ Nosebleeds _____
Heart Condition _____ Stomach Condition _____
Operations _____ Serious Injuries _____
Urinary Tract Problems _____ Pneumonia/Bronchitis _____
Skin Problems _____ Bowel Problems _____
Diabetes _____ Dental Problems _____
Contact with TB _____ Menstrual Problems/Pregnancy _____

Physical or activity restrictions _____

Medications at Home _____

Medications needed at school _____

(If yes, please request form from school nurse – we must have physician order for all prescription and over-the-counter medications)

Child's Doctor _____ Last seen _____

Doctor's Address and Phone Number _____

Have you ever suspected that your child may have a vision problem? _____

Does he/she wear glasses _____ Contacts _____

Has he/she ever been to an optometrist or specialist? _____

If so, what was the result of the exam and recommendations, if any? _____

Have you ever suspected that your child may have a hearing problem? _____

Has he/she ever had a hearing test? _____ DATE _____

If so, what was the result of the exam and recommendations, if any? _____

NYS Education Department requires a physical exam for students in PreK or K, 2, 4, 7 & 10, sports, working permits, and, triennially, for the Committee on Special Education (CSE). This exam is valid for one year through the last day of the dated month with the exception of any illness or injury lasting more than five days that will negate that exam.

Please indicate if you prefer the exam to be performed by your family physician. _____

Parent needs to send copy of the physical to the School Nurse. Please inform the nurse of physical date by October 1.

I agree to emergency medical treatment as deemed necessary by school authorities.

DATE: _____ **PARENT/GUARDIAN SIGNATURE** _____