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 a form from the school nurse - we must have a physician order for all prescriptions 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 new students and students in PreK or K, 1, 3, 5, 7, 9 & 11; annually for sports; working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE). 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 the exam.

Please indicate if you prefer the exam to be performed by your family physician._____
Parent needs to send a copy of the physical to the School Nurse. Please inform the nurse of the physical date by October 1 or one will be done by the school physician.
I agree to emergency medical treatment as deemed necessary by school authorities.

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