NORTH GREENBUSH COMMON SCHOOL DISTRICT

Health History Form

TO BE FILLED OUT BY PARENT

Child's Name_____ Date of Birth_____
Address _____ Home Phone_____
Mother's Name_____ Employer_____
Home Phone _____ Cell Phone _____
Father's Name_____ Employer_____
Home Phone _____ Cell Phone_____
Guardian's Name_____ Employer_____
Home Phone _____ Cell Phone _____
Does your child take any medication regularly? Yes_____ No_____
If yes, what medication? _____
Reason for medication? _____
~If medication is to be given during school hours, additional school medication form must be completed by a physician. *(Form may be acquired at the District Office)*

Has your child had in the past, or does he or she presently have, any of the problems listed below?

	YES	NO
Allergies or reaction to food or medication	___	___
Hay Fever, Asthma or wheezing	___	___
Eczema or frequent skin rashes	___	___
Convulsions or seizures	___	___
Heart trouble	___	___
Diabetes	___	___
Frequent colds, sore throats, earaches (6/yr or more)	___	___
Serious injury	___	___
Surgery	___	___
Speech problems	___	___
Hearing problems	___	___
Congenital defect	___	___
Dental problems (Date of last exam_____)	___	___
Developmental lag	___	___
Wears glasses	___	___
Any visual concerns	___	___

If you answered yes to any of the above, please provide a brief description:
_____
Is there anything else that you think we should know about your child?
_____

Parent's Signature_____ Date_____