Pittsford Central School District

Student Health Information Form

To be completed by parent or guardian and returned to the School Health Office

Child's Name ______________________________ Birthdate __________ Grade ______ Sex M / F
Physician's Name __________________________________ Phone ____________________
Dentist's Name ____________________________________ Phone ____________________
Date of last physical exam ______________ Preferred Hospital ______________________

Health History (check all that apply and explain below)

ADD/ADHD	Chicken Pox	Heart Condition	Scoliosis
Anemia	Dental Injuries	Hernia Repair	Seizure Disorder
Arthritis	Diabetes	Hypertension	Single Organ
Asthma /trouble breathing	Ear Infections	Mental Health/Psych Issue (depression, eating disorder anxiety, OCD, ODD, etc.)	Skin Condition
Autism/Asperger's/etc.	Gastrointestinal Condition (ulcer, reflux, IBS, etc.)		Speech Condition
Bleeding Disorder			Urinary/Kidney Problem
Cancer	Headaches/Migraines	Orthopedic Condition	
Vision Deficit Wears Glasses Contacts		Hearing Deficit Hearing Aid Cochlear Implant	
Allergies (specify type of allergy: environmental, food, insects, latex, medication and previous reactions)			
Congenital Condition			
Concussion with or without loss of consciousness (list dates injury occurred)			

Please list any hospitalizations or surgeries:

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Please list any injuries requiring medical care:

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Does your child receive treatments or use assistive equipment during or outside the school day?

Insulin/blood glucose monitoring Inhaler/nebulizer/peak flow monitoring Special diet

Crutches Walker Wheelchair Other ______________________________

Does your child take medication either at home or at school? (list name, dose, and time(s) of administration)

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Is there any condition that would prevent your child from participating in physical education or sports?

No Yes ____

Additional Information: ______________________________________

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Completed by: ______________________________________ Date: ______________

Please Return to: