

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)

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

Please list any hospitalizations or surgeries:

Please list any injuries requiring medical care:

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)

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

No Yes _____

Additional Information: _____

Completed by: _____ Date: _____

Please Return to: