**Horseheads Central School District**
**Medical Information Form**

**Student's Name** _____ **Date of Birth** _____

**Gender** Male or Female (circle one) **Grade** _____

**Physician Name** _____ **Physician's Phone** _____

**Dentist Name** _____ **Dentist's Phone** _____

Please assist the Health Office in better serving your child by answering the following questions:

**Has your child had any of the following:**

| | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| If yes, date of last seizure _____ | | |
| Asthma | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Allergies to: | | |
| Bees/insect | ☐ | ☐ |
| Food _____ | ☐ | ☐ |
| Medication | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

**Does your child need/use:**

| | Yes | No |
|---|---|---|
| Glasses/Contacts | ☐ | ☐ |
| Hearing Aids | ☐ | ☐ |
| Assistive Devices (wheelchair, walker or braces) | ☐ | ☐ |
| Medications | ☐ | ☐ |

If yes, ☐ at school
☐ at home

Medications: _____
_____

| | Yes | No |
|---|---|---|
| Has your child ever had speech therapy? | ☐ | ☐ |
| Has your child ever had any serious accidents, operations, or hospitalizations? | ☐ | ☐ |
| Does your child require any medical services at school? | ☐ | ☐ |
| Does your child have a history of frequent ear infections? | ☐ | ☐ |
| Does your child have any other medical and/or emotional issues? | ☐ | ☐ |

**If you have answered yes to any questions above, please explain**:

_____

_____

**Do both parents reside at same address? Yes or No If No, please list name & address of who the child physically resides with:** _____

**I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.**

_____ _____
Parent/Guardian Signature Date

**Reviewed by the School Nurse** _____

MEDICAL INFORMATION FORM