Mechanicville City School District

MEDICAL HISTORY FORM

Student's Name: _____DOB ____/____/____ Sex: M F
Last First Middle (Circle One)

Address: _____ City _____ Zip _____

Mother's Name (including maiden): _____Phone: _____

Father's Name: _____Phone: _____

Physician to be called: _____Phone: _____

Has your child ever had any of the following? Please complete:

Chicken Pox	NO _____	YES _____	DATE _____
Measles	NO _____	YES _____	DATE _____
German Measles	NO _____	YES _____	DATE _____
Mumps	NO _____	YES _____	DATE _____
Scarlet Fever	NO _____	YES _____	DATE _____
Hepatitis	NO _____	YES _____	DATE _____
Pneumonia	NO _____	YES _____	DATE _____
Tuberculosis (TB)	NO _____	YES _____	DATE _____
Whooping Cough	NO _____	YES _____	DATE _____
Fifths Disease	NO _____	YES _____	DATE _____
Head Injury/Concussion	NO _____	YES _____	DATE _____
Frequent Sore Throat	NO _____	YES _____	DATE _____
Ear Illness/Tubes	NO _____	YES _____	DATE _____
Rheumatic Fever	NO _____	YES _____	DATE _____
Heart Disease	NO _____	YES _____	DATE _____
Kidney Disease	NO _____	YES _____	DATE _____
Cerebral Palsy	NO _____	YES _____	DATE _____
Epilepsy	NO _____	YES _____	DATE _____
Asthma	NO _____	YES _____	DATE _____

PLEASE COMPLETE IN DETAIL THE FOLLOWING QUESTIONS RELATING TO YOUR CHILD

1) Does your child have allergies? _____ What kind? _____

   Any allergies to food? _____ What food(s)? _____

   Describe allergic reaction: _____

   Is it life threatening? _____ **If your child is allergic to any foods, your physician must document it and the cafeteria & teacher will be notified.**

2) Has your child had any operations/serious injuries? _____ If yes, what & when _____

   _____

   _____

3) Does your child have any urination/bowel problems that the school should be aware of? _____

   _____

4) Is there anything concerning the eyes, ears or general health of your child which the school should know in order to provide special care? _____

   _____

   _____

5) Does your child wear eye glasses for reading, distance or both? _____

6) Is your child on any medication? _____ If yes, what medication/reason? _____

   _____

   _____

   Will any need to be administered during school hours? _____

- **ALL MEDICATIONS PRESCRIPTIONS AND OVER-THE-COUNTER, REQUIRE A PHYSICIAN'S WRITTEN ORDER (EXAMPLE: LOTIONS, CREAMS, OINTMENTS, COUGH MEDICINES, SUNTAN LOTION, COUGH DROPS, ANALGESICS, ETC.) AN ADULT MUST BRING THE MEDICINE IN A PHARMACY/ORIGINAL LABELED CONTAINER TO THE NURSE'S OFFICE WHERE IT WILL BE KEPT IN A LOCKED CABINET AND ADMINISTERED ACCORDINGLY.**

7) Does your child have any limitations on activities including recess on playground equipment and Physical Education class? _____

   _____

IF SO, AN ANNUAL PHYSICAL ACTIVITY FORM MUST BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.