

**Cold Spring Harbor Central School District**

**Pupil's Health History**

(To be completed by parent/guardian)

***Please Print***

Student's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Teacher (if known) \_\_\_\_\_ Entering Grade \_\_\_\_\_

Doctor & Phone \_\_\_\_\_ Dentist & Phone \_\_\_\_\_

Does this child have any allergies? \_\_\_\_yes \_\_\_\_no

IF "yes" please list \_\_\_\_\_

Has allergy required emergency treatment or medication?

IF "yes" please explain \_\_\_\_\_

Does this child have any medical conditions? (asthma, diabetes, etc.)

If "yes" please explain \_\_\_\_\_

Does this child take any medication regularly at home? \_\_\_\_yes \_\_\_\_no

If "yes" please describe \_\_\_\_\_

Does this child require medication at school? \_\_\_\_yes \_\_\_\_no

If "yes" please explain \_\_\_\_\_

Is there a history of any hospitalizations, injuries or surgery? \_\_\_\_yes \_\_\_\_no

If "yes" please explain \_\_\_\_\_

Does this child have a special diet? \_\_\_\_\_

Any additional concerns or pertinent information you would like the nurse to know?(use back as needed)

\_\_\_\_\_

Date

\_\_\_\_\_

Parent or Guardian Signature