

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