

OSNABURG LOCAL SCHOOLS
School Health History

Student's Name _____

Date of Birth _____ Grade _____

1. Please check all that apply to your child's medical history:

Bee Sting Allergy Asthma Diabetes ADD/ADHD
 Seizures/Epilepsy Chicken Pox Heart trouble Latex Allergy

**If any of the above was checked, please explain _____

2. Does your child have any allergies? (medicine, food or environmental) yes no

**If yes, please list _____

3. Does your child have any other medical, emotional or behavioral problems that might affect him/her at school? yes no **If yes, please explain _____

4. Does your child have a health problem that would require any special care at school?

yes no **If yes, please explain _____

5. Has your child had any surgery? (i.e. ear tubes, eye surgery, tonsillectomy) yes no

**If yes, please list type of surgery and age when surgery was performed _____

6. Does your child take medication regularly? yes no **If yes, please complete:

Medication: _____ Medication: _____

Amount taken: _____ Amount taken: _____

How often: _____ How often: _____

Will it be taken at school? _____ Will it be taken at school? _____

****Authorization form must be completed and on file in the office before any medication can be administered at school!! If there's a prescription we must also have a letter from the doctor with child's name, name of medicine and dosage.**

7. Does your child have any vision problems? yes no Wear glasses/contacts yes no

8. Does your child have a speech problem? yes no; Hearing problem? yes no

9. Does your child have any limitations that the gym teacher should be aware of? yes no

**If yes, please explain _____

This information may be shared with the educational team to best meet your child's needs.

Child's Doctor _____ Doctor's phone number _____

Parent/Guardian Signature _____ Date _____