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_____