Mamaroneck Union Free School District

CHILD MEDICAL HISTORY INFORMATION

(To be completed by Parent or Guardian at the beginning of each school year)

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following form. Information is confidential and may be shared with teaching staff as needed. **Return form to school nurse as soon as possible.** Thank you.

Child's name: (Please print)_____**Date of birth:** _____ **Boy** ❒ **Girl** ❒

Grade: _____ **Teacher/Counselor:** _____

School: ❒ Central ❒ Chatsworth ❒ Mamaroneck Avenue ❒ Murray
❒ Hommocks ❒ High School ❒ Other _____

Lives at home with:

(Name)_____; Mother (Name)_____; Father

Siblings/Others: (Name)_____; Male ❒ Female ❒ ; date of birth _____; relationship:_____

(Name)_____; Male ❒ Female ❒ ; date of birth _____; relationship:_____

(Name)_____; Male ❒ Female ❒ ; date of birth _____; relationship:_____

(Name)_____; Male ❒ Female ❒ ; date of birth _____; relationship:_____

(Name)_____; Male ❒ Female ❒ ; date of birth _____; relationship:_____

Child Caretaker: (Name) _____ Male ❒ Female ❒ ; relationship:_____

Doctor's name: _____ Date of last physical: _____

Dentist's name: _____ Date of last visit: _____

Is child under an orthodontist's care? No ❒ Yes ❒ **Doctor's name:** _____

Birth history: Any complications or problems during pregnancy and/or delivery? No ❒ Yes ❒

Please describe: _____

Full term birth? No ❒ Yes ❒ If no, how premature was child? _____ (weeks). Birth weight: _____lbs. _____ oz.

Has this child ever had (a):	YES	Date:		YES	Date:
Chicken Pox……..	❒	_____	Meningitis……	❒	_____
Encephalitis……	❒	_____	Rheumatic fever	❒	_____
Lyme disease……	❒	_____	Positive TB test ……	❒	_____
Bleeding tendency….	❒	_____	Pneumonia……	❒	_____
High Blood Pressure…	❒	_____	Kidney disease……	❒	_____

Any complications from above illnesses? (please explain)_____

Does child have or has child ever had:

- Allergies? Yes ❒
  To drugs, food, insects, pollen? Please list:_____
  Has the allergy required emergency action in the past? No ❒ Yes ❒
  What happens to child? _____
- Asthma? Yes ❒
  Triggered by: _____ Treatment: _____
  Diagnosed by doctor? _____ Date: _____
  Uses: inhaler ❒ nebulizer ❒ other medication ❒
  Taken: at home only ❒ may need medication at school ❒
- Attention Deficit Disorder? Yes ❒
  Is your child taking medication for this now? No ❒ Yes ❒
  Name of medication: _____ Dose (mg): _____
  How often does he/she take it? _____

OVER PLEASE ☞

- Bee sting allergy? Yes ❒ Describe reaction: _____
  Difficulty breathing? No ❒ Yes ❒
  Need emergency medication? No ❒ Yes ❒
- Bone or joint problems or broken bones? Yes ❒ Describe: _____
  Any physical restrictions? _____
- Diabetes? Yes ❒ Takes insulin? No ❒ Yes ❒ Date diagnosed: _____
- Dizziness, loss of consciousness, fainting or lost memory?……Yes ❒
- Heart condition, murmur, or irregular heart beat? Yes ❒ Describe: _____
  Any physical restrictions? No ❒ Yes ❒
  What are they? _____. Medication? No ❒ Yes ❒
- Past history of increased lead levels in the blood?…… Yes ❒ When? _____ What was the level? ____
- Loss of an eye, kidney, testicle or other organ?……Yes ❒
- Previous head injury? Yes ❒ At age: _____ Describe: _____
- Seizures? Yes ❒ Describe seizure: _____
  Date of last seizure: _____ Medication: _____
  Is student currently under a doctor's care for seizure? No ❒ Yes ❒

Has this child had any other illness? _____

Does your child take any other daily medication at home? No ❒ Yes ❒ **At school?** No ❒ Yes ❒
Name of medication: _____ Reason for taking it: _____

Has this child had any condition which required emergency treatment or hospitalization? No ❒ Yes ❒

If yes, for what?	Ate age:	How long in hospital?	Surgeries (operations)?
_____	_____	_____	_____
_____	_____	_____	_____

Check off the following health categories/concerns that pertain to your child:

◇Eyes: wears glasses ❒; wears contacts ❒ : for reading ❒, for distance ❒, all the time ❒; single vision? ❒

◇Ears: frequent infections ❒; ear tubes present ❒, since _____

wears hearing aid : right ear ❒ left ear ❒ hearing difficulty: explain: _____

◇Other:

❒ nosebleeds	❒ requires diapering	❒ sleeping difficulties	❒ eating too little
❒ headaches/migraines	❒ requires catheterization	❒ dental concerns	❒ phobias
❒ bowel	❒ bed wetting	❒ eating too much	❒ menstruation
❒ bladder			

Does this child have any medical, physical, learning, or emotional problems that the school should know about? (handicaps; parents recently separated; etc.) _____

Does any relative or anyone in the home have tuberculosis, diabetes, or other illness? _____

Describe: _____

Has your child been evaluated by any of the following professionals? (in the last 12 months):

❒ audiologist	❒ occupational therapist	❒ psychologist	❒ speech/language therapist
❒ neurologist	❒ physical therapist	❒ psychiatrist	❒ other: _____

Please list any other health concerns you have for your child: _____

✕ _____ _____

(Signature of legal parent/guardian) (Date)