





# SOUTHERN WESTCHESTER BOCES

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

Student Name : \_\_\_\_\_

District: \_\_\_\_\_

## HEALTH HISTORY INFORMATION

Doctor's Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Is student taking medication? \_\_\_\_\_ If so, why? \_\_\_\_\_

Name of Medication(s): \_\_\_\_\_

Dosage? \_\_\_\_\_

Frequency? \_\_\_\_\_

Student has the following condition(s) which require special consideration in an emergency:

\_\_\_\_\_

Any Physical Reaction(s)? \_\_\_\_\_

Has student had any of the following?

Epilepsy [ ] Yes [ ] No

Asthma [ ] Yes [ ] No

Allergies [ ] Yes [ ] No

Bee Sting [ ] Yes [ ] No

Diabetes [ ] Yes [ ] No

Heart Disease [ ] Yes [ ] No

Loss of Consciousness [ ] Yes [ ] No

Head Injury [ ] Yes [ ] No

Kidney Disease [ ] Yes [ ] No

Blood Pressure Problem [ ] Yes [ ] No

Vision Impairment [ ] Yes [ ] No

Hearing Impairment [ ] Yes [ ] No

If so: Grand Mal [ ] Petit Mal [ ]

Type: \_\_\_\_\_ Acuteness: \_\_\_\_\_ Presents with: \_\_\_\_\_

If so, indicate treatment: [ ] Oral Med. [ ] Injection [ ] Hospital

If so, date of injury: \_\_\_\_\_

Date of last Tetanus Injection? \_\_\_\_\_

Other medical information:

\_\_\_\_\_

*I have read the above information and answered the questions to the best of my knowledge.*

*I am the parent/guardian of the child named on this application. In the event he/she needs emergency treatment and I cannot be reached, I request the emergency treatment be administered at the nearest hospital.*

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE