# LEVITTOWN PUBLIC SCHOOLS
## HEALTH SERVICES
### MEDICAL HISTORY
*(MUST BE COMPLETED BY PARENT/GUARDIAN)*

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Birthdate</th>
<th>Grade</th>
</tr>
</thead>
</table>

If your child has a history of, or is being treated for the following conditions, please indicate below:

- Frequent colds:_________________________
- Frequent sore throats:_____________________
- Ear Condition:__________________________
- Hearing Loss:___________________________
- Heart Disease:_________________________________________________________________
- Asthma:______________________________________________________________________
- Vision Problem:____________________________________
- Wears Glasses:____________
- Operations/Date:_______________________________________________________________
- Serious Injury/Date:_____________________________________________________________
- Hospitalization/Reason/Date:_____________________________________________________
- Orthopedic Problem:_____________________________________________________________
- Seizure Disorder/Date last seizure:______________________________________________
- Allergies:   Latex__________  Bee Sting __________  Environmental ____________________
  - Food Allergies (List) ______________________________________________________
  - Medication Allergies: ____________________________
  - What happens when exposed to allergen?________________________________________
  - Medications received on regular basis:__________________________________________
  - Speech evaluation/therapy:____________________________________________________

Please specify any other health information you feel will be helpful in meeting your child needs:

_____________________________________________________________________________

Date:  ___________     Signature of Parent/Guardian_______________________________