**LEVITTOWN PUBLIC SCHOOLS**
**HEALTH SERVICES**

# MEDICAL HISTORY
**(MUST BE COMPLETED BY PARENT/GUARDIAN)**

_______________________________________________________________

**Student's Name** **Birthdate** **Grade**

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

Frequent colds: _________________ Frequent sore throats: __________________

Ear Conditions: _________________ Hearing Loss: ________________________

Heart Disease: ____________________________________________________________

Asthma: _________________________________________________________________

Vision Problem: ___________________________ Wears Glasses ___Yes ___ No

Operations/Date: __________________________________________________________

Serious Injury/Date:_________________________________________________________

Hospitalization/Reason/Date:__________________________________________________

Orthopedic Problem:_________________________________________________________

Seizure Disorder/Date of 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's needs:_______________________________________________________________

_________________________________________________________________________

Date: _________ Signature of Parent/Guardian:________________________