

West Seneca Central School District
CONFIDENTIAL HEALTH HISTORY

TO BE COMPLETED BY PARENTS

Registration Date _____

Pupil's Name _____ Birth Date _____
(Last) (First) (Middle)

Birth Place _____ Grade _____ Sex _____ Home Phone _____

Address _____
(Number) (Street) (Town) (Zip Code)

Father's Name _____ Mother's Name _____

Health Care Provider's Name _____ Health Care Provider's Phone Number _____

Preschool History: Please give dates (if they apply) – use other side to explain further.

Anemia	Nephritis	Joint Problems	Frequent Colds
Chicken Pox	Pneumonia	Bladder Problems	Operations
Diabetes	Rheumatic Fever	Allergies to Insect Stings	Fractures
Epilepsy	Scarlet Fever	Asthma	Serious Injuries
Heart Disease	Strep Throat	Other Allergies	Scoliosis
Hepatitis	Mononucleosis	Ear Conditions	Convulsions
		Fainting Spells	Staring Spells

SPECIAL TESTS	DATE	RESULT	TAKEN BY WHOM
Tuberculin Tests			
X-Rays			
Electrocardiogram (Heart EKG)			
Electroencephalogram (Brain Wave EEG)			
Allergy Tests			
Blood Tests			

Does child have allergies? Yes _____ No _____ If yes, what is the allergy and describe reaction. Explain on back. →

Does child have any congenital abnormalities or defects? If yes, please explain on back. →

Has child been hospitalized for any illnesses, injuries, or operations? _____ If yes, please give dates and explain on back. →

Any vision problems? _____ Has this child had an eye exam? _____ Eye surgery? _____ Eyes patched? _____

Eye exercises? _____ Wears glasses? _____ Explain on back. →

Have any history of hearing loss? _____ Repeated ear infections? _____ Tubes in ears? _____ Date(s) _____

Is his/her speech understandable to others? _____

Does this child take any medication routinely (excluding vitamins)? _____ If yes, what medicine, how often taken, and for what reason? _____

Will it be necessary to take medicine during school hours? _____

Are there any special problems or conditions we should know about to better understand your child? _____

REGARDING THE GROWTH AND DEVELOPMENT OF THIS CHILD

Birth weight _____ Premature birth? _____ Age at which your child Walked _____ Toilet trained _____

Age at which your child Used single words _____ Simple sentences _____

History of any identified medical concerns _____

If you wish to have a conference scheduled with the school nurse, please check here.

The back of this form may be used for any additional information or explanations.