Canandaigua City School District
Committed to Excellence

	TELEPHONE	FAX
Primary School Health	585-396-3940	585-396-3779
Elementary School Health	585-396-3910	585-396-3954
Middle School Health	585-396-3860	585-396-3874
Academy School Health	585-396-3820	585-396-3957

Medical History Form

Name of Child: (Last)_____(First)_____(Middle)_____

M _____ F_____ Birth Date: _____

Parent/Guardian Name: _____
Name of Physician: _____
Name of Dentist: _____

Parent/Guardian: If you answer yes to any of the following questions, explain your answer in the comment section.
Is your child currently under physician's care? Yes _____No _____ If yes, for what reason?
_____

Is your child currently taking medication? Yes_____ No _____
If yes, name of medication - _____

Will your child need medication at school? Yes _____ No _____
If yes, type -_____

Has your child ever been hospitalized and/or seen in emergency for illness, surgery or injury?
Yes ___No ___
If yes, explain –_____

Did you have any difficulty during pregnancy, labor or delivery? Yes _____ No _____
If yes, explain - _____

Was your child premature? Yes _____ No _____

Is your child toilet trained? Bladder _____ age _____ Bowel _____ age _____
Is your child independent in the bathroom? Yes _____ No _____
If no, you must consult with your child's doctor and develop a plan.

PLEASE COMPLETE SECOND PAGE

Health History

Has your child had or does he/she now have any of the following?

	YES	NO
Pneumonia		
Chicken Pox		
Emotional difficulties		
Nervous disorders		
Hyperactivity		
Seizures/Convulsions		
Joint Disease		
Lead poisoning		

	YES	NO
Diabetes		
Frequent high fevers		
Dizzy/fainting spells		
Meningitis		
Severe headaches		
Head injury – unconsciousness		
Strep throat		
Heart disease		

Fractures? Yes ____ No _____ If yes, type _____

Frequent ear infections? Yes____ No _____

Hearing difficulties? Yes____ No ____ If yes, does your child have hearing aids or tubes? _____

Vision difficulties? Yes ____ No ____ If yes, has your child seen an eye doctor / wear glasses? _____

Asthma? Yes ____ No ____
List triggers: _____
Treatment for symptoms: _____
Will your child need an inhaler or nebulizer at school? Yes ___ No ____

Allergies? Yes ____ No ____
Types: _____
Treatment for: _____
Triggers: _____
Will your child need Benedryl or an Epipen at school? Yes ___ No ___

Is there anything else about your child's health, past or present, that the school nurse should be aware of in order to provide the best possible learning experience?

If your child has significant health concerns, please contact the Primary Health Office to schedule an appointment to discuss his/her health in detail.

Date: _____

Parent/Guardian signature: _____