Cold Spring Harbor Central School District
Pupil's Health History
(To be completed by parent/guardian)
Please Print

Student's name_____ Date of Birth_____

Teacher (if known)_____ Entering Grade_____

Doctor & Phone_____ Dentist & Phone_____

Does this child have any allergies? _____yes _____no

IF "yes" please list_____

Has allergy required emergency treatment or medication?

IF "yes" please explain_____

Does this child have any medical conditions? (asthma, diabetes, etc.)

If "yes" please explain_____

Does this child take any medication regularly at home? ____yes _____no

If "yes" please describe_____

Does this child require medication at school? _____yes _____no

If "yes" please explain_____

Is there a history of any hospitalizations, injuries or surgery? ___yes ____no

If "yes" please explain_____

Does this child have a special diet?_____

Any additional concerns or pertinent information you would like the nurse to know?(use back as needed)

_____ _____

Date Parent or Guardian Signature

FORM B