Pupil Health History Form

St. Augustine School

Ossining Union Free School District

Child's Name_____ Date of Birth_____ Phone_____

Address_____

Physician_____ Office Phone_____

Dentist_____ Office Phone_____

If student has any of the following please indicate and supply dates:

CONDITION	Yes	No	Comments if "Yes"
Attention-Deficit/Hyperactivity Disorder			
Allergies (food, insects, drugs, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Behavioral problems			
Developmental problems			
Bladder problems			
Bleeding problems			
Bowel problem			
Cerebral Palsy			
Cystic Fibrosis			
Dental Problems			
Diabetes			
Head or spinal injury			
Hearing problems or deficit			
Heart problems			
Hospitalizations (when, why)			
Lead poisoning			
Muscular problems			
Seizures			
Sickle Cell Disease (not trait)			
Speech problems			
Surgery (when, why)			
Vision problems			
Other:			

Does your child take any medication on a daily or regular basis? If so what and when?_____

_____

*If a medication needs to be administered at school a prescription from your doctor is required and a separate medicine container to be left at school.

_____ _____ _____

Parent/Guardian Signature Date Relationship