GARDEN CITY PUBLIC SCHOOLS
STUDENT HEALTH FORM

CONFIDENTIAL

School: _____

Student: _____ Student ID #: _____ Grade: _____

Please check below any conditions affecting your child which may affect his/her welfare in school. For example: Asthma, Diabetes, Seizure Disorder, Vision or Hearing Defect, Severe Allergies, etc.

ALLERGIES

- □ Food Allergy
- □ Insect Allergy
- □ Latex Allergy
- □ Drug Allergy
- □ Environmental Allergy

OTHER CONDITIONS

- □ Asthma
- □ Cardiac Heart Condition
- □ Diabetes
- □ Gastrointestinal Condition
- □ Hearing Problems
- □ Kidney Condition
- □ Neurological Condition
- □ Orthopedic/Bone Condition
- □ Past Hospitalizations
- □ Past Surgeries
- □ Pulmonary/Lung Condition
- □ Recent Injuries
- □ Seizure Disorders
- □ Vision Problems or Corrective Lenses
- □ OTHER

Please list and explain any items checked above and any illnesses, injuries or health problems the child has had in the past year or is currently being treated for:

_____

_____

_____

_____

Please list the medication with dosages your child takes on a regular basis. Please include prescription and over the counter medications:

	Name of Drug	Dose and Frequency	Reason
1.			
2.			
3.			
4.			

My child wears:

- □ Glasses
- □ Contacts
- □ Hearing Aid(s)
- □ Orthodontic Braces
- □ Other Brace:
- □ Arm
- □ Leg
- □ Back

Other medical information school needs to know:

_____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____

Information contained in this form, will be shared on a "need to know" basis.