ELMIRA CITY SCHOOL DISTRICT

951 Hoffman Street
Elmira, NY 14905
Phone: (607) 735-3000
www.elmiracityschools.com

STUDENT HEALTH INFORMATION AND HISTORY FORM

INSTRUCTIONS: Complete this form for each child to be registered. Parents are urged to provide for their child's complete physical, dental, ear, and eye exams before school entrance. Parents are required to provide proof of immunizations by State Law. **PLEASE PRINT CLEARLY.**

STUDENT INFORMATION					
Student' s Name		Date of Birth		Grade	

Place an X in the Yes or No column for each condition below. If Yes, enter the date of treatment and provide explanation below.

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Chicken Pox				Bee Sting Allergy				High Lead Level			
German Measles				Severe Food Allergy				High Blood Pressure			
Measles				Dizziness w/Exercise				Heart Problems/Murmur			
Mumps				Allergies/Hay Fever				Concussion			
Anemia				Single Testicle				Headaches			
Diabetes				Physical Handicap				Ear Problems			
Seizure Disorder				Rheumatic Fever				Hearing Loss			
Heart Disease				Scarlet Fever				Ankle Injury			
Fainting Spells				Pneumonia				Fractures or Dislocation			
Nose Bleeds				Asthma				Knee Injury			
High Cholesterol				Serious Injuries				Eye Problems			
Spleen Injury				Problem Birth				Vision Loss			
Neck or Back Injury				Operations				Uncorrectable Vision Loss			
Bladder/Kidney Problems				Hospitalization				Glasses or Contact lenses			
Single Kidney											

Health History – Please explain any YES above. Use back of page if extra space is needed.

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Family Doctor ____________________ Address ______________________________

City ____________________ State __________ Phone ____________________

1. [ ] Yes [ ] No Has there been a sudden death of a family member under 50 years of age?
   Cause: ______________________________

2. [ ] Yes [ ] No Has your child ever been evaluated at any clinic such as heart, speech, hearing, mental health, etc.?
   Clinic Name and Address: ______________________________

3. [ ] Yes [ ] No Is your child taking any medications? Please List Medications: ______________________________
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4. [ ] Yes [ ] No Will your child be taking any medications at school? **If Yes, please speak to school nurse.**

5. [ ] Yes [ ] No Does your child have any medication allergies? If Yes, please name: ______________________________
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6. [ ] Yes [ ] No Has your child ever attended another ECSD school before?
   Which one(s): ______________________________

Parent or Guardian Signature: ______________________________ Date: ____________