Elmira City School District

Administration Building
951 Hoffman Street
Elmira, NY 14905

Phone: (607) 735-3000
www.elmiracityschools.com

Student Health Information and History

Student's Name _____ Date of Birth _____ Grade _____

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.

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.

_____

_____

_____

_____

Family Doctor _____ Address _____

City _____ State _____ Phone _____

1. [ ] Yes [ ] No Has there ever 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: _____
   _____

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: _____
   _____

6. [ ] Yes [ ] No Has your child ever attended another ECSD school before?
   Which one(s): _____

Parent or Guardian Signature: _____ Date: _____