LOCKPORT CITY SCHOOL DISTRICT - HEALTH HISTORY FORM

State law requires that all new entrants produce proof of sufficient vaccine status. ***THEREFORE: A COPY OF IMMUNIZATIONS FROM A DOCTOR OR CLINIC IS REQUIRED – PLEASE ATTACH TO THIS FORM.***

I understand that the information contained on this form will be kept confidential and may be shared with school and transportation personnel if needed to protect the student's health and safety while at school.

STUDENT'S NAME: ____ BIRTHDATE: __________

(First) (Initial) (Last)

ADDRESS:____ PHONE:______________________________

BIRTHPLACE: ____ SEX: ( ) Female ( ) Male

(City) (State) (Country)

NAME OF PHYSICIAN: ______________________________ NAME OF DENTIST: __________________________________

HEALTH CONDITIONS PLEASE CHECK ANY THAT APPLY TO YOUR CHILD

___ Abnormal spinal curvature (scoliosis, etc.)
___ Asthma or wheezing
___ Depressed immune system
___ Sickle cell disease/Blood disorder
___ Seizure disorder
___ Diabetes
___ Pregnancy
___ Broken bones ____
___ Other (please specify): ____
___ Any Surgeries: _________________________

___ Ear infections (more than 3 in one year)
___ Tubes in ears: Left ____ Right ____
___ Wears hearing aid
___ Wears glasses/contacts
___ Other visual impairment ______________
___ Orthopedic impairment _______________
___ Heart Condition/murmur _____________
____ Any Restrictions: ___________________

___ Head injury or loss of consciousness
___ Frequent headaches
___ Frequent nosebleeds
___ Fainting or blacking out
___ Concern about relationship with siblings or friends
Behavioral / Emotional problems
___ Substance abuse: ___ Drugs ___ Alcohol
___ Depression
___ Suicide attempt

*** Please describe/explain the health conditions noted above, along with any other concerns which you feel the school should be aware of on the back of this form:

ALLERGIES: (Please list and describe reactions): ____

SEVERE ILLNESSES OR INJURIES: ____

DAILY MEDICATIONS AND DOSAGE: (please list and explain associated medical condition) ______________________

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OTHER: ____

______________________________	______________________________	____________________________	______________
(Print name of person completing this form)	(Signature of person completing this form)	(Relationship to student)	(Date completed)

Explanation of health conditions from other side:

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Other concerns or comments:

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