

**LEVITTOWN PUBLIC SCHOOLS
HEALTH SERVICES**

**MEDICAL HISTORY
(MUST BE COMPLETED BY PARENT/GUARDIAN)**

Student's Name	Birthdate	Grade
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If your child has a history of, or is being treated for the following conditions, please indicate below:

Frequent colds: _____ Frequent sore throats: _____

Ear Condition: _____ Hearing Loss: _____

Heart Disease: _____

Asthma: _____

Vision Problem: _____ Wears Glasses: _____

Operations/Date: _____

Serious Injury/Date: _____

Hospitalization/Reason/Date: _____

Orthopedic Problem: _____

Seizure Disorder/Date last seizure: _____

Allergies: Latex _____ Bee Sting _____ Environmental _____

Food Allergies (List) _____

Medication Allergies: _____

What happens when exposed to allergen? _____

Medications received on regular basis: _____

Speech evaluation/therapy: _____

Please specify any other health information you feel will be helpful in meeting your child needs:

Date: _____ Signature of Parent/Guardian _____