LEVITTOWN PUBLIC SCHOOLS
HEALTH SERVICES

MEDICAL HISTORY
(MUST BE COMPLETED BY PARENT/GUARDIAN)

_____

Student's Name **Birthdate** **Grade**

If your child has a history of, or is being treated for the following conditions, please indicate below:

Frequent colds: _____ Frequent sore throats: _____

Ear Conditions: _____ Hearing Loss: _____

Heart Disease: _____

Asthma: _____

Vision Problem: _____ Wears Glasses ___Yes ___ No

Operations/Date: _____

Serious Injury/Date:_____

Hospitalization/Reason/Date:_____

Orthopedic Problem:_____

Seizure Disorder/Date of 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's needs:_____

_____

Date: _____ Signature of Parent/Guardian:_____