Levittown Public Schools – Medical History

Student Name: ____

Birthdate: ______________________ Grade Level: ___________

Please complete any medical information to provide for the school nurse. You are required to submit a physical exam within the current year as well as current immunization records. Information on this page will be reviewed by the school nurse. You may receive a call from the nurse if further clarification is required.

Primary Doctor's Name: ________________________ Primary Doctor's Phone: ______________

Do you authorize the nurse to contact your child's primary doctor regarding medical information? Yes No

Medications Taken

Specify any medication, if taken daily or as needed and if medication should be taken at home or at school. This information will be shared with administrator and support staff. All medication administered in school will require a doctor's order.

Medical Considerations

List any significant health concerns, medical diagnoses or special needs. This may include heart related issues, asthma, vision or hearing problems, reactions from allergies or physical disabilities.

Medical History

List past and present illnesses, injuries or surgeries.

Vision Details – (circle that applies)

Nearsighted **Farsighted**

Wears – (circle that applies)

Glasses Only **Contacts Only** **Both Glasses and Contacts**

Allergies - *Specify allergies including medication, insects, food, animals etc. Separate each allergy with a comma.*

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Dietary/Lunch Restrictions - *Indicate directions for lunch purchases or food considerations that are NOT allergy related.*

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Signature of Parent/Guardian: ______________________________ Date: ____________