

SOUTH ORANGETOWN CENTRAL SCHOOL DISTRICT

NAME _____ M/F _____ BIRTH-
(SEX) DATE _____ GR. _____

Please list Name, Telephone No. and Date of Last Visit to: _____

PHYSICIAN _____
DENTIST _____
EYE DOCTOR _____
OTHER SPECIALIST _____

In the last year has your child had any of the following:
(Please explain and describe treatment).

ALLERGIC REACTION _____

ACCIDENT CAUSING INJURY _____

HOSPITALIZATION _____

LONG OR UNUSUAL ILLNESS _____

FREQUENT STREP THROAT _____

FREQUENT EAR INFECTIONS _____

VISION PROBLEM _____

HEART MURMUR OR OTHER HEART PROBLEM _____

PNEUMONIA OR ASTHMA _____

G.I. SYMPTOMS _____
(Frequent stomach aches, diarrhea etc.)

G.U. SYMPTOMS _____
(Kidney or Bladder infection)

CONVULSION OR NERVOUS TIC _____

BROKEN BONE, SPRAIN ETC. _____

MEDICATION ON A REGULAR BASIS _____

ANY REASON TO MODIFY SCHOOL ACTIVITY _____

Please add any comments regarding your child's growth and
development that you wish the school nurse to know.

HIS. 2

PARENT OR GUARDIAN SIGNATURE