NORTH SYRACUSE CENTRAL SCHOOL DISTRICT

HEALTH RECORD AND HISTORY FORM

Name:	DOB: Grade: Age:	Gender: □ M □ F
Parent/Guardian: (*person completing this form*)	Home Phone: Cell Phone:	Date:
Physician:	Phone #:	Date of last physical exam:

I give permission for the above student to have a school physical: □ YES □ NO

Has your child ever:	**YES**	**NO**	**If YES, please explain and include date:**
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies: *Food, Environment, Insect, Medication or Other*			
Been hospitalized			
Had an operation			
Had an injury requiring an Emergency Room Visit			
Missed 5 days of school in a row due to illness/injury			
Had a bone/muscle injury			
Passed out, had a concussion or serious head injury			
Had a convulsion/seizure			
Had a vision problem or condition: *Glasses, Contacts or Color Blind*			
Had a hearing problem or condition: *Hearing Aid or Cochlear Implant*			
Worn dental bridge, braces or mouthpiece			
Have any family members under the age of 50 ever:	**YES**	**NO**	**If YES, please specify:**
Had a heart attack or other serious health Issues			

CHECK ALL THAT APPLY TO YOUR CHILD:

□ ADHD □ Asthma/Trouble Breathing □ Autism/ Asperger □ Dental Injuries □ Diabetes □ Ear Infections

□ GI Conditions (Ulcer, Reflux, IBS) □ Headaches/Migraines □ Heart Conditions □ High Blood Pressure □ Mental Health Condition: (Depression, Eating Disorder, Anxiety, OCD, ODD, etc.) □ Scoliosis □ Single Organ (Kidney, Testicle) □ Skin Condition □ Speech Condition □ Urinary Condition

History of: □ Rheumatic Fever □ Chicken Pox □ Reoccurring Strep Throat □ Scarlet Fever □ Tuberculosis

CURRENT MEDICATIONS	**YES**	**NO**	**Please list: NAME/DOSE/TIME(S)**
Given at School			
Taken at Home			
ASSISTIVE EQUIPMENT at SCHOOL	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School:			□ Crutches □ Walker □ Wheelchair □ Other
TREATMENTS	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School			□ Insulin □ Blood Glucose Monitoring □ Inhaler/Nebulizer/Peak Flow Monitoring □Special Diet

Has your child tested positive for COVID-19:

Yes: ____ No: ____ Date: _____

Is there any condition that would prevent your child from participating in physical education or sports? □ YES □ NO

_____

_ _

Please list any additional concerns: (Use back of sheet if necessary):_____ **PARENT/GUARDIAN SIGNATURE**_____**DATE:** _____ Student

Name: _____Grade: _____ DOB: _____

North Syracuse Central School District

FOOD ALLERGY AWARENESS INFORMATION

Does your child have any known food allergies/intolerances? □ YES (Continue) □ NO (Stop/Sign Form)

FOOD ALLERGY

What age was the student diagnosed with an allergy? _____

Specific food allergies? _____

□ Pure food, list allergies: _____

□ As an ingredient, list allergies: _____

Reaction signs:_____

Is medication required? _____

Is antihistamine in Nurse's Office? _____

Is Epinephrine (Epi-Pen) in Nurse's Office?_____

NON MEDICAL DIETARY RESTRICTIONS: _____

FOOD INTOLERANCE:

□ Pure food, list food intolerance(s): _____

□ As an ingredient, list specific ingredients(s): _____

Reaction signs: _____

If lactose intolerant, is it: □ Milk

□ Yogurt
□ Ice Cream
□ Cheese
□ All types of food or beverages that contain milk

Has the student been hospitalized as a result of an allergic reaction? □ YES □ NO

If student has **peanut** or **tree-nut** allergy, can student eat anything manufactured in a plant that processes items with peanuts and tree-nuts? □ YES □ NO

A physician's note must be submitted to the school nurse if you are reporting a food allergy/intolerance for the first time or there has been a change in your child's allergy/intolerance status. A physician's note can be faxed or submitted in person to appropriate school.

Please read the school's Student Food Allergies Policy (8101.2) located on the district website, www.nscsd.org.

Signature indicates agreement to allow the NSCSD to share information on this document with appropriate personnel.
Parent/Guardian Signature: _____ Date: _____