NORTH TONAWANDA CITY SCHOOL DISTRICT
HEALTH INFORMATION

Date _____ Grade Entering _____

Child's Name _____ Birth Date_____ Sex_____

Address _____ Home Phone _____

Father's Full Name _____

Mother's Full Name _____

With whom does this child live? _____
Relationship

Last school attended _____

Has child attended another N.T. School? _____

IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING DISEASES, PLEASE FILL IN THE YEAR.

*Chickenpox	_____	Rheumatic Fever	_____	Asthma	_____
Diphtheria	_____	Scarlet Fever	_____	Ear Condition	_____
*German Measles	_____	Whooping Cough	_____	Diabetes	_____
*Mumps	_____	Kidney Condition	_____	Heart Disease	_____
*Measles	_____	Tuberculosis	_____	Contact with TB	_____
Anemia	_____	Other	_____		

*** Dr.'s verification necessary. If not available, must be immunized.**

Is your child subject to any of the following?

Speech Difficulty _____ Emotional Problems _____
Poor Hearing _____ Frequent Respiratory Problems _____
Other Conditions (Specify) _____

Family Physician _____ Phone _____

In accordance with Public Health Law 2164 a Principal cannot permit a child to be admitted unless a person in parental relationship to the child furnishes the school with immunization records.

Does your child have any allergies	Yes	No	To what?	_____
Does your child wear glasses?	Yes	No		
Has your child ever been hospitalized?	Yes	No	When_____	For what _____
Has your child ever had surgery?	Yes	No	When_____	For what _____
Has your child ever had a blood transfusion?	Yes	No	When	_____
Has your child ever passed out due to head injury?	Yes	No	When	_____
Has your child ever injured any bones or joints?	Yes	No		
Be specific_____			When?	_____
Is your child allergic to latex?	Yes	No	(example: balloons, band-aids, latex gloves)	
Is your child taking any regular medication at home?	Yes	No	If so, what	_____
Does your child have a history of seizures?	Yes	No	When_____	Type _____

(over)

NORTH TONAWANDA CITY SCHOOL DISTRICT
Allergy Information

Date _____

Child's Name _____

Address _____

Home Phone _____

WHAT KIND OF ALLERGY DOES YOUR CHILD HAVE?

Hay fever (e.g. nasal and sinus problems) Yes No

What time of year? _____

Is medication given at home? Yes No

If yes, what kind? _____

Medication Yes No

What medication? _____

What kind of reaction? _____

Foods Yes No

If so, what kinds of foods? _____

_____

What kind of reaction? _____

_____

Latex (e.g. balloons, band aids, latex gloves) Yes No

What kind of reaction? _____

_____

Bee stings Yes No

What kind of reaction? _____

_____

Is medication required? Yes No

If yes, what kind? _____

Animals Yes No

Which ones? _____

What type of reaction? _____