North Babylon Union Free School District

Medical Information

Name_____ Date of Birth_____

School_____ Grade_____

Family Physician_____Phone (____)_____

Significant Medical/Surgical History:
___See attached

Specify Current Diseases:

____Asthma ____Diabetes _Type 1 ___Type 2
____Hyperlipidernia ____Hypertension
____Other

Allergies:

____Life Threatening _____Food:_____
____Seasonal _____Insect:_____
_____Other:_____

Medication:_____

Medications (list all):

_____None

Name_____Dosage/Time_____

Name_____Dosage/Time_____

Name_____Dosage/Time_____

_____ Check if your child has will be examined by a family physician to satisfy the district's requirement for the child to participate in inter-scholastic sports.

_____ Check if your child has had any allergies, illnesses or injuries in the past year or has taken any medication on a daily basis. Please list medications and anything the school should know on this card in order to give your child special care.

_____Check here if your child will be examined by a family physician. The New York State Education Law requires that every new entrant to school and students in grades K, 1, 3, 5, 7, 9, & 11 be examined by his/her private physician or a school physician.

If proof of a physical examination is not submitted by October 1st, your child will be examined by the school physician.

In case of illness or serious injury and no authorized adult (listed on front of this card) can be reached, please transport my child to the nearest hospital emergency room by ambulance if necessary. I realize that the school district cannot assume responsibility for medical fees or expenses incurred.

_____ _____

Signature of Parent / Guardian Date

NORTH BABYLON UNION FREE SCHOOL DISTRICT

Student's Name _____ Grade _____ Room _____

Address _____ Telephone # _____

Male _____ Female _____ Date of Birth _____ Place of Birth _____

Parent / Guardian Names: _____ Place of Birth _____

_____ Place of Birth _____

Personal and Confidential History

1. Sibling names and ages _____

2. With whom is this child living? _____

3. Is this child in Foster Care? _____ Agency _____

   Caseworker _____ Telephone _____

4. Language spoken at home _____

5. Last school attended _____ Address _____

Health History

Has your child ever had the following health problem(s)?

Pneumonia	__ year __	Mumps	__ year __	Allergies	__ year __
Chicken Pox	__ year __	Seizures	__ year __	Kidney condition	__ year __
Measles	__ year __	Epilepsy	__ year __	Bladder condition	__ year __
Rubella	__ year __	Lyme disease	__ year __	chronic ear problem	__ year __
Rheumatic Fever	__ year __	Tuberculosis	__ year __		

Asthma __ year __ Is he/she on medication for Asthma now? ____ Name of medication _____

Heart Condition __ year __ Restrictions _____

Diabetes __ year __ Is there a history of Diabetes in your family? _____

Hypertension __ year __ Is there a history of Hypertension in your family? _____

(Continued on opposite side of page)

Medical Information

1. Medication
   a) Is your child currently taking any prescribed medication? Yes _____ No _____
   b) If yes, name of medication and reason it is taken _____
   c) Is it necessary for this medication to be taken during school hours? Yes _____ No _____
   d) Name, address and telephone number of physician monitoring this medication:

      Name _____ Address _____ Phone _____

2. Does your child require eyeglasses to do school work? Yes _____ No _____

3. Does your child require a hearing aid in order to do school work? Yes _____ No _____

4. Does your child have (or do you suspect your child of having) any of the following conditions?
   a) Visual impairment? Yes _____ No _____
   b) Hearing impairment? Yes _____ No _____
   c) Speech / Language impairment? Yes _____ No _____
   d) Other physical impairments or handicaps? Yes _____ No _____ Specify _____

   If you have answered yes to any of the questions a – e above, then you must complete items f – j below:

   e) Other serious illness? Yes _____ No _____ Specify _____

      Name _____ Address _____ Phone _____

   f) Name, address and telephone number of physician treating the above condition.

   g) Has your child received special school services or restrictions for this condition? Yes _____ No _____

   h) By whom has your child been served in school? _____

   i) What has the frequency of service been? _____

   j) When was service last received? _____

5. Has your child been hospitalized since birth? Yes _____ No _____ Dates _____
   If so, indicate reasons for hospitalizations(s):

   _____

   _____

   _____

   _____

Parent / Guardian Signature: _____ Date: _____