NORTH MERRICK UNION FREE SCHOOL DISTRICT
North Merrick, New York

Health Record

For Office Use Only

Building:_____

Teacher:_____

Name	**Sex**	**Date of Birth**	**Birthplace**

Address	**Telephone Number**

Father's Full Name
Mother's Full Name

Physician's Name, Address, Telephone Number
Dentist's Name, Address, Telephone Number

Medical History

Please indicate ***Yes*** **or** ***No*** to the childhood diseases listed below:

Chicken Pox (specify with date) _____
Seizure Disorder _____
Diabetes _____
Heart defect _____
Orthopedic problems _____
Operations _____
Serious illness/injury _____
Asthma _____
Allergies _____
Chronic ear infection _____
(more than two years)

Defective vision/hearing _____
Medical problems immediately after birth _____
Medication (on regular basis) _____
Any other physical problem _____
Psychological therapy/ testing _____
Speech therapy/testing _____
Does child have unusually short attention span? _____
Is child dealing with family stress(illness, death, separation)? _____
Restriction of physical activity _____

If the answer to any of the above questions is yes, please indicate age of occurrence and give further details on the other side.

_____
Parent Signature