OUR LADY OF SORROWS SCHOOL-WHITE PLAINS, NY 10605

Office Of Medical And Health Services

Registration – Medical History

Child's Name: _____ DOB: _____

Address: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

PAST AND PRESENT ILLNESSES: Has your child had any of the following conditions? (Yes/No)

	Yes	No		Yes	No		Yes	No
Allergies			Ear Infections (frequent)			Emotional Disability or Mental Illness		
Anemia			Fainting			Seizure Disorder		
Asthma			Frequent Headaches			Skin Rashes		
Cancer			Heart Disease			Positive Tuberculin Test		
Diabetes			High Blood Pressure			Other		
			Immunodeficiency					

If you answered "Yes" to any of the above, please explain: _____

_____

Does your child take any medication? _____ Name: _____

For what reason? _____

Has your child had a serious injury or illness that required hospitalization? ____ If "Yes", explain:

_____

Does your child have poor vision? _____ Left Right Wear glasses? _____

poor hearing? _____ Left Right

Parents should directly inform the school nurse if their child has a life threatening allergy or illness to ensure their safety in school.

Please check the appropriate statement.
CHECK ONLY ONE:

____ I give the nurse permission to share this information, if necessary, with teachers and staff associated with my child's educational experience.

____ I do not give the nurse permission to share this information with teachers and staff associated with my child's educational experience.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: (please print) _____

OUR LADY OF SORROWS- HEALTH SERVICES

Student Allergy Form-For Registration

Date: _____

_____ _____ _____

LAST NAME FIRST NAME DATE OF BIRTH

ALLERGIES: _____

_____

At what age was your child diagnosed with an allergy? _____

What physician made this diagnosis? (Pediatrician/ Allergist)?

Current physician: Name _____ Phone _____

Address _____

What symptoms led to this diagnosis? _____

_____

Has your child had any of the following?

Skin testing for allergies? Yes___ No ____ Blood Testing? Yes___ No___

A Food Challenge? Yes___ No___

Is your child currently taking any medication? Yes___ No___ If yes, please list any medications:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many allergic reactions has your child experienced? _____

Has an Epi Pen ever been administered to your child? _____

Has your child ever been hospitalized for an allergic reaction? _____

Is your child aware of his/her allergies? Yes____ No___ Had a reaction in school/camp? Yes___ No___

Do you have any issues/concerns you would like to share with the nurse? _____

_____

Does your child have an EpiPen prescribed for him/her? Yes___ No___