Granville Central School District
MEDICAL HISTORY

Student's Name _____ Student's Physician _____
Date of Birth _____ Student's Dentist _____
Student's Grade _____

Prenatal History

Month Prenatal Care Began 1 2 3 4 5 6 7 8 9
Pregnancy Complications _____
Delivery Complications _____
Full Term _____ Premature _____ Birth Weight _____
Birth Defects _____

Developmental History (approximate age)

Sat Alone _____ Crawled _____ Walked _____
Fed Self _____ Dressed Self _____
Spoke: Words _____ Sentences _____
Toilet Trained:(AM & PM) Bladder _____ Bowel _____

Medical Problems - Check Here if NONE _____

Allergies: Medicine _____
Food _____
Seasonal _____
Daily Medications _____
Frequent Medications _____

A Dr. note is required if there any dietary restrictions in school.

Does Your Child Have or Has Had Any of the Following:

_____ Anemia	_____ Asthma	_____ Lyme Disease
_____ Bronchitis	_____ Pneumonia	_____ ADHD
_____ Chickenpox	_____ Whooping Cough	_____ Obsessive Compulsive Disorder
_____ Scarlet Fever	_____ Rheumatic Fever	_____ Oppositional Defiant Disorder
_____ Meningitis	_____ Tuberculosis	_____ Bipolar Disorder
_____ Measles	_____ Urinary Tract Infections	
_____ Fainting	_____ Frequent Colds	
_____ Seizures	_____ Frequent Sore Throat	
_____ Concussion	_____ Frequent Headaches	
_____ Fractures	_____ Dislocations	

Lyme Disease ADHD

Family History: Check if *S*tudent, *M*other, *F*ather, *Sibl*ing or Grandparent Have Any

_____ Allergies	_____ Arthritis	_____ Emotional Problems
_____ Asthma	_____ Heart Disiease	_____ Kidney Disease
_____ Cancer	_____ Liver Disease	_____ Cerebral Palsy
_____ Hepatitis	_____ Tuberculosis	_____ Speech Problems
_____ Epilepsy	_____ Vision Problems	_____ Learning Disability
_____ Diabetes	_____ Hearing Loss	_____ Chronic Illness

Has Your Child

Had Any Serious Injury or Illness? _____
Been Hospitalized? (reason) _____
Surgery? (when & what) _____

over

1. Is your child under the care of a doctor for any reason at the present time? yes no
   If yes, please explain:

2. Does your child have any hearing problems? yes no
   If yes, please explain:

3. Does your child have any vision problems? yes no
   If yes, please explain:

4. Does your child wear glasses or contact lenses? yes no
   If yes, are they to be worn during school? yes no
   How often? All times Reading only
   Other (please explain)

5. Does your child have any need for special attention due to health problems? yes no
   If yes, please explain:

6. Are there any limitations to any activities? yes no
   If yes, please explain:

7. Is there any other health information that would be helpful? yes no
   If yes, please be specific:

Parent/Guardian _____ **Date** _____