

DEPOSIT CENTRAL SCHOOL
Deposit, New York

Updated Student Information Medical Form

The Health Office at the Deposit Jr./Sr. High School is in the process of updating the records of our students. Please complete the following form and return it to our Health Office.

STUDENT NAME: _____ BIRTHDATE: _____

PARENT(S) GUARDIAN NAME: _____

ADDRESS: _____

TELEPHONE #: _____ DURING SCHOOL HOURS #: _____

STUDENT MEDICAL HISTORY

Date of Last Physical Exam: _____

Family Physician: _____

Address: _____

YES/NO

YES/NO

YES/NO

___ ___ Current medical Treatments

___ ___ Chronic Medical Conditions

___ ___ Skin Disorder

___ ___ Allergies to any drug/
medications

___ ___ Cardiac/Heart Conditions

___ ___ Kidney Problems

___ ___ Allergy to bee stings

___ ___ High Blood Pressure

___ ___ Diabetes

___ ___ Asthma

___ ___ Anemia or Blood Pressure

___ ___ Tuberculosis

___ ___ Hayfever or allergies in general

___ ___ Fainting Spells or Seizures

___ ___ Sinus Problems

___ ___ Tubes in Ears

___ ___ Liver Problems or Hepatitis

___ ___ Surgery

___ ___ Excessive bleeding
from cut or a nosebleed

___ ___ Frequent Ear Infections

___ ___ Broken Bones

___ ___ Any current medications. Please state name of medicine and why it is being given: _____

If any of the above are checked "YES", please comment in space provided: _____

Please share with us any other pertinent information that you feel would be beneficial: _____

I have read and understand these questions, and the answers given by me are true to the best of my knowledge. I understand that I must report promptly any changes to the school Health Office.

Parent / Guardian Signature

Date