BEDFORD CENTRAL SCHOOL DISTRICT
School Health Services
THE FOX LANE CAMPUS, P.O. BOX 180
MOUNT KISCO, NEW YORK 10549
914-241-6000

Dr. Robert Glass
Superintendent of Schools

Dr. Louis Corsaro
Medical Director

Health History

Name of Student: _____ ☐ **Male** ☐ **Female** ☐ **Non-Binary**

Grade: _____ **Date of Birth:** _____

The School Health Services will gladly cooperate with you if your child has any health issues that might affect his/her education. Please update the following questions in order to help us in planning for a positive educational experience for your child.

1. History of serious illness or operations	
2. History of asthma/allergies	
3. Is your child currently receiving any medical treatment?	
4. Is your child currently on any medications? If yes, please list medication(s):	☐ Yes ☐ No
5. Does your child wear glasses? Does your child wear contact lenses? If yes, under what conditions does he/she wear them?	☐ Yes ☐ No ☐ Yes ☐ No
6. Does your child have a hearing difficulty? If yes, please describe	☐ Yes ☐ No
7. Should your child be restricted from physical activity? If yes, please describe	☐ Yes ☐ No
8. Are there any special health needs you wish to bring to our attention such as problems of behavior, growth, or nutrition?	

Please check the appropriate box:

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

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

_____ _____

Signature of Parent/Guardian Date