

CRANFORD PUBLIC SCHOOLS
Cranford, New Jersey

MEDICAL HISTORY FORM

Please return this form with the registration packet

Name: _____ **Date of Birth:** _____ **Gender: M** _____ **F** _____

If the student is transferring from another School, please complete below:

Name/address of School/phone number _____

Health Information (to be completed by parents)

Asthma _____ Diabetes Type 1 _____ Diabetes Type 2 _____ Seizure disorder _____

Seasonal Allergies (please list) _____

Food/nonfood Allergies _____ Antihistamine required: Y _____ N _____ Epipen required: Y _____ N _____

List allergies and symptoms of reaction _____

Cardiac (please describe) _____

Cancer (please describe) _____

Eczema _____ Pneumonia _____ Bronchitis _____ Frequent ear infections _____

Thyroid _____ Hepatitis _____ Lyme Disease _____ Chicken Pox _____

Rheumatic Fever _____ Tuberculosis _____ Meningitis _____ Other _____

Immune Disorder (please describe) _____

Operations, serious injuries (please list) _____

Vision/hearing difficulty _____ Any other relevant disability _____

Medications (please list) _____

I understand that the school nurse should be informed of any changes or additions to the above information before the first day of school.

Parent Signature: _____ **Date** _____

(Revised 5/2016)