Lewiston-Porter Central School District

PLEASE COMPLETE THIS REQUIRED FORM IF YOU WANT YOUR STUDENT EXAMINED BY OUR SCHOOL DOCTOR

RETURN THIS FORM TO THE NURSE OR FAX TO THE MS NURSE @ 286-7267
HS NURSE @ 286-7853

STUDENT NAME: _____ Date of Birth: _____ Age: ____ Grade: _____

1. Has your child had a recent illness, accident or injury? _____ Yes _____ No

Explain: _____

2. Does your child have any of the following?

	Yes	No			Yes	No
Anemia				Allergies		
Arthritis				Medication		
Asthma			Inhaler Y__ N__	Food		
Kidney Disease				Bee Sting		
Seizures				Environmental		
Diabetes				If yes to any of the above, please explain the reaction and treatment needed_____ _____ _____		
Migraine Headaches						

3. Does your child have any orthopedic problems? _____ Yes _____ No

Explain: _____

4. Does your child have any history of heart problems, murmurs, dizziness or fainting? _____ Yes _____ No

Explain: _____

5. Are there any significant medical issues our school MD should be aware of? _____ Yes _____ No

Explain: _____

I hereby state that, to the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of Parent/Guardian Date

Andrew M. Auer, High School Principal
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