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)