CRANFORD PUBLIC SCHOOLS Cranford, New Jersey

MEDICAL HISTORY FORM Please return this form with the registration packet

Name:	Date	of Birth:	Gender: N	VIF	_
If the student is transfe Name/address of School					
Health Information (to	be completed by pa				
Asthma Dial	oetes Type 1	_ Diabetes Type 2	Seizu	ıre disord	er
Seasonal Allergies (plea	ase list)				
Food/nonfood Allergie	s Antihistam	nine required: Y	N Epipen r	equired: \	/ N
List allergies and sympt	coms of reaction				
Cardiac (please describ	e)				
Cancer (please describe	e)				
Eczema Pne	umoniaB	ronchitis F	requent ear in	ıfections_	
Thyroid	Hepatitis	Lyme Disease	e C	hicken Po	x
Rheumatic Fever	Tuberculosis_	Meni	ngitis	Other_	
Immune Disorder (plea	se describe)				
Operations, serious inju	uries (please list)				
Vision/hearing difficult	у	Any other relev	ant disability_		
Medications (please lis	t)				
I understand that the s information before the		e informed of any o	:hanges or ad	ditions to	the above
Parent Signature:				Date_	
(Revised 5/2016)					