

FAMILY AND PERSONAL MEDICAL HISTORY

FAMILY HEALTH HISTORY		
	YES	NO
Tuberculosis		
Diabetes		
Kidney Disease		
High Blood Pressure		
Arthritis		
Stomach Disease / Ulcer		
Asthma, Hay Fever, Eczema		
Epilepsy, Convulsions		
Cancer		
Emotional Problems		
Anemia		
Alcohol / Drug Abuse		

PERSONAL HEALTH HISTORY					
	YES	NO		YES	NO
Scarlet Fever Disease			Rheumatic Fever		
Measles Disease			Heart Murmur		
Mumps Disease			High Blood Pressure		
Chicken Pox Disease			Dizziness or Fainting		
Mononucleosis Disease			Convulsions or Epilepsy		
Malaria Disease			Arthritis		
Sinusitis			Back Problems		
Diabetes			Stomach or Intestinal Trouble		
Frequent Anxiety			Jaundice or Hepatitis		
Frequent Depression			Recurrent Diarrhea		
Worry or Nervousness			Surgery(list dates)		
Recurrent Headaches			Head Injury		
Recurrent Colds			Trauma/ Injury		
Allergies (spec.) Penicillin			Transfusions		
Allergies: other drugs			Urinary Tract Infections		
Hay Fever, Asthma			History of Fractures		

Medication	YES	NO
Are you currently taking any medication?		
Please list : (include birth control pills)		

New York State Department of Health requires Authorization for the Administration of Medications.

Parent/ Guardian and Physician signature required.

- Tylenol 325mg 1-2 tabs every 3-4hours
- Ibuprofen 200-800mg every 4-6 hours
- Pseudoephedrine (Sudafed) 30mg. 1-2 tabs every 4-6 hours
- Benadryl 25mg 1-2 tabs every 4-6 hours
- Milk of Magnesia 30 cc, hours of sleep, as needed
- Mylanta 30cc
- Tums chewable tabs
- Anbesol for cold sores
- For severe allergic reactions: EPI-PENN (epinephrine 1-1000) 0.3cc IM
- Emetrol 1-2 tsps as needed
- Immodium AD 1 capsule every 4-6 hours as needed
- Claritin 1 tab q24hrs prn
- Tussin 2 tsp every 4 hours prn
- Zyrtec 1 tablet q24hrs prn

Parent or guardian _____

Date _____

Physician signature _____

Date _____

Address _____

Phone # _____