



**KENDALL ELEMENTARY SCHOOL**  
KENDALL, NEW YORK 14476  
585-659-8317

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Medical History**

1. Were there any complications surrounding the pregnancy, labor, or delivery time with your child?  
\_\_\_\_\_

2. Has he/she had any:

a. serious illness/es?      Yes      No      Please list with approximate date. \_\_\_\_\_

b. childhood diseases?      (please circle)      Verified by doctor      approximate date  
    chicken pox      Yes      No      Yes      No      \_\_\_\_\_

c. serious accidents?      Yes      No      Please list with approximate date. \_\_\_\_\_

d. allergies?      Yes      No      Please list and described reaction if exposed: \_\_\_\_\_

e. been hospitalized?      Yes      No      had any surgery?      Yes      No  
    Please list when and why: \_\_\_\_\_

f. head injuries? \_\_\_\_\_

3. Does he/she take any medicine?      Yes      No      If so, what kind? \_\_\_\_\_

4. Is he/she frequently ill?      Yes      No      If so, type of illness? \_\_\_\_\_

5. Does he/she have any visual problems?      Yes      No      Wear eyeglasses?      Yes      No

6. Does he/she have any known hearing difficulties? Yes      No      If so, please explain. \_\_\_\_\_

7. Does he/she have any dental problems? Yes      No      If so, please explain. \_\_\_\_\_

8. Does he/she have any artificial parts (i.e. eye, limb, dental, etc.)?      Yes      No      If so, please list \_\_\_\_\_

9. Has your child had any problems (physical or emotional) for which you have sought outside help? Yes      No  
    If so, from what source? \_\_\_\_\_

Physician's Name \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Phone Number \_\_\_\_\_

Address: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital Used: \_\_\_\_\_

Other Concerns, Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_