MINISINK VALLEY CENTRAL SCHOOL DISTRICT

P.O. Box 217, Slate Hill, NY 10973

School Health Examination

Parent Completes

Child's Name: ________________________ Parent / Guardian Name(s): ________________________

Address: ____

Home Phone: ________________________ Work Phone: ________________________

Date of Birth: __________ Age: __________ Sex: __________ Grade: __________ School building (circle one): OS ES IS MS HS

Does your child have any allergies (i.e) bees, food, medication, etc? ________________________

If yes, what reaction does he/she have? ________________________

What do you do for treatment? ________________________

Is your child currently taking any medication? ________________________

I give my permission for the Minisink Valley CSD school physician to complete the required medical examination.

________________________________ ________________

Signature of Parent / Guardian Date