

GESU PRESCHOOL
2450 MIRAMAR BLVD.
UNIVERSITY HTS., OH 44118
(216) 932-0620, ext. 129

Student's Name _____ Grade _____

Address _____ Phone _____ Birthdate _____

Please complete the following and return to the nurse immediately.

Immunization History: Please attach a copy of student's immunization record.

Please check any of the following your child has had or may have at present:

	<u>Yes</u>	<u>Medication</u>	<u>Disease</u>	<u>Year</u>
Allergy (please name)	___	_____	Chicken Pox	_____
Asthma	___	_____		
Diabetes	___	_____		
Seizure Disorder	___	_____		
Fainting Spells	___	_____		
Heart Murmur	___	_____		

Any other problems for which medication is taken? _____

Does your child have any allergies? _____

List past history of illness, injury, or hospitalization. Specify: _____

Does your child have any disability? If so, please explain: _____

Does he/she wear glasses _____; have a hearing loss _____; or a speech concern _____?

SIGNATURE: _____

Parent/Guardian