

SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT

_____SCHOOL

HEALTH DATA SHEET

Student _____ Date of Birth _____ Gender _____
Mother's Name _____ Father's Name _____
Mother's Phone # Home _____ Work _____ Father's Phone # Home _____ Work _____
Mother's Address _____ Father's Address _____

With whom does this child live? ~ Both parents ~ Mother ~ Father ~ Guardian ~ Other _____

Emergency Contact if parent/guardian cannot be reached:

Name _____ Relationship to student _____ Phone # _____
Student's physician _____ Phone # _____

PRENATAL AND DEVELOPMENTAL HISTORY

Did the mother have any unusual problems/illness during the pregnancy or the birth such as breech, forceps or Cesarean delivery? Yes ~ No ~ If yes, please explain briefly: _____

Was this infant born: Full term? ~ Premature? ~ Postmature? ~

What was this infant's birth weight? _____ lb _____ oz

Did this infant have any sickness or problems while in the hospital, such as jaundice, apnea spells or convulsions? Yes ~ No ~ If yes, please explain briefly: _____

Please give an approximate age at which this child: sat up alone _____ walked _____
said single words _____ said sentences _____ was toilet trained _____

Please briefly describe this child's overall development in relation to his/her other siblings:

HEALTH CONDITIONS

Please check any that are a chronic problem.

- ~ Diabetes ~ High fevers
- ~ Eye Problems ~ Seizures
- ~ Poor vision ~ Epilepsy
- ~ Poor hearing ~ Toothaches
- ~ Crossed Eyes ~ Dental infections
- ~ Tubes in ears ~ Bowel Problems
- ~ Frequent ear infections ~ Bed wetting
- ~ Frequent headaches ~ Heart problems
- ~ Frequent nosebleeds ~ Other _____
- ~ Frequent sore throats

Has your child ever had the chicken pox? Yes ~ No ~ If yes, when? _____

MEDICAL INFORMATION

Does this child have any allergies? Yes ~ No ~ If yes, to what? _____

What treatment or medication does this child require for this/these allergies? _____

Does this child have asthma that has been diagnosed by a physician? Yes ~ No ~ If yes, what treatment and/or medication has been prescribed? _____

Does this child have any medical condition other than listed above? Yes ~ No ~ If yes, please explain. _____

INJURIES, ILLNESSES AND SURGERIES

Please list any severe injuries, illnesses and/or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If hospitalized, how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL INFORMATION

Is this child on daily medication? Yes ~ No ~ If yes, please list. _____

Is this child on medication on a regular basis, but not daily? Yes ~ No ~ If yes, please list. _____

Do any family members have any long-term illness, such as diabetes, cancer, high blood pressure, etc.? Yes ~ No ~
If yes, please list the illness and the relationship of the person to this child. _____

For girls only: If applicable, give age of first menstrual period _____ Any Problems? Yes ~ No ~
If yes, please explain. _____

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? Yes ~ No ~ If yes, please explain. _____

Completed by: _____
Relationship to child: _____

Date: _____

Would you like a conference with the school nurse? Yes ~ No ~