WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

# School Health Services

_____SCHOOL

*For Office Use Only: Please Return Form to Health Office*

## HEALTH DATA SHEET

Student _____ Date of Birth _____Gender ____
Parent Name _____ Additional Parent Name_____
Parent Phone # Home _____ Work _____ Cell _____
Additional Parent Phone # Home _____ Work _____ Cell _____
Parent Address _____
Additional Parent Address _____

With whom does this child live?
□Both Parents □ Parent □ Additional Parent □Guardian Other_____

Student's Physician _____ Phone # _____

Emergency Contact if parent/guardian cannot be reached:

Name _____ Relationship to Student _____
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 □ Post mature
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:___

_____

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## School Health Services: HEALTH CONDITIONS

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Please check any that are a chronic problem.

☐ Diabetes ☐ Seizures ☐ Epilepsy ☐ Heart Problems

*If your child has any of the above, please contact the school nurse.*

☐ High Fevers ☐ Eye Problems ☐ Poor Vision ☐ Poor Hearing ☐ Crossed Eyes
☐ Tubes in Ears ☐ Bed wetting ☐ Bowel Problems ☐ Toothaches ☐ Dental Infections
☐ Frequent Ear Infections ☐ Frequent Headaches ☐ Frequent Nosebleeds
☐ Frequent Sore Throats ☐ Other _____

### MEDICAL INFORMATION

Does this child have any allergies? ☐ Yes ☐ No

If yes, to what? _____
What are the child's triggers to this/these allergies? _____

What are the child's reactions to this/these allergies? _____

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: _____

_____

_____

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## ADDITIONAL INFORMATION

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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. _____

_____

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: _____ Date: _____

Relationship to child: _____

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