

**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?
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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## 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: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

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