WAPPINGERS CENTRAL SCHOOL DISTRICT
School Health Services

_________________________________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:
____

Last Updated 1/2016

HEALTH CONDITIONS

Please check any that are a chronic problem.

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

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 _____ 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