WAPPINGERS CENTRAL SCHOOL DISTRICT | Empower Challenge Grow

School Health Services

_____SCHOOL

GRADES 1 – 12 HEALTH DATA SHEET

Student _____ Date of Birth _____Gender ____
Mother's Name _____ Father's Name_____
Mother's Phone # Home _____ Work _____ Cell _____
Father's Phone # Home _____ Work _____ Cell _____
Mother's Address _____
Father's Address _____

With whom does this child live?
☐Both Parents ☐Mother ☐Father ☐Guardian Other_____

Student's Physician _____ Phone # _____

Emergency Contact if parent/guardian cannot be reached:

Name _____ Relationship to Student _____
Phone # _____

School Health Services: HEALTH CONDITIONS

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 _____

Has your child ever had the chicken pox? ☐ Yes ☐ No

If yes, when? _____

What is the date of your child's first Polio vaccination? _____

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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: _____
_____

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. _____

_____

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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