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: _____ Date: _____
Relationship to child: _____

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