PORT JERVIS CITY SCHOOL DISTRICT
HEALTH HISTORY

Child's Last Name First Name Middle Name Date of Birth

Street Address Apt./Bldg/Unit # Town Zip Code

Mailing Address, including PO Box # (if different from street address)

Natural Mother's full name: ____
Natural Father's full name: ____
Step Parent's full name____
Guardian's full name____
Child lives with : Both parents_______; Mother_______; Father_______; Guardian_______
Step-Parent_________ Other;_______
Home phone: ___________________
Mom's cell phone__________________Mom's work # _________________Employer_________________
Dad's cell phone __________________ Dad's work # __________________Employer_________________
Other Emergency Names and numbers:
____

Are there any CUSTODY issues we should be aware of? Be specific: _______________________________

Does your child have –OR- has your child ever had any of the following (check all that apply):

€ Eating issues €weight issues €head injury / concussion
€ eye injury €vision problems €glasses / contacts
€ seizures €hearing problems €speech problems

Does your child have FREQUENT:

€colds €sore throats €sinus infections €tonsillitis
€headaches €migraines €ear infections €bronchitis
€eczema €rashes €other: ______________________________

Does your child have a history of –OR- currently being treated for any of the following:
(Please indicates dates, current treatment or medication)

€ADHD__________________________ €Scoliosis______________________________
€Diabetes________________________ €Thyroid problems__________________________
€Toileting problems__________________ €Kidney/Urinary problems____________________
€Heart murmur_____________________ €Heart Disease_____________________________
€Blood Disorder____________________ €Operations_______________________________
€Hospitalizations____________________ €Broken bones/fractures______________________
€Osgood Schlatter Syndrome__________ €Other: __________________________________

When was the last time your child went to the dentist: _________

Complete page 2, sign and date

NAME____

ASTHMA: Does your child have asthma that has been diagnosed by a doctor? € Yes € No
If YES, what type: € chronic € bronchial € exercise € other: ________________________________
ASTHMA MEDICATION: What type of asthma treatment does your child use? Be Specific ; € INHALER € NEBULIZER € PILL: __________________ € OTHER________________________

ALLERGIES: Does your child have ANY allergies? € Yes € No known allergies
Which allergies have been diagnosed / confirmed by a doctor? ____
Please list ALL allergies and your child's REACTION (Be specific)
FOODS________________________________ LACTOSE INTOL______________________________
BEES _________________________________ INSECTS ______________________________________
ANIMALS____
ENVIRONMENTAL/SEASONAL____
DRUGS/ANTIBIOTICS______________________ OTHER____
What medication / treatment does your child take for allergies?____

Do you have any OTHER HEALTH CONCERNS about your child? ____

** MEDICATION NOTE**
In order for a child to receive ANY medication in school, over the counter and/or prescription, the following is required:

1. MEDICATION FORM COMPLETED BY DOCTOR AND SIGNED BY PARENT
2. MEDICATION MUST BE IN ORIGINAL CONTAINER
3. CONTAINERS MUST HAVE STUDENT'S NAME ON IT
4. MEDICATION MUST BE BROUGHT TO SCHOOL BY AN ADULT. STUDENTS ARE NOT PERMITTED TO CARRY MEDICATION.

NEW YORK STATE MANDATED PHYSICALS AND SCHOOL HEALTH SCREENINGS:

PHYSICALS are required as follows:
→All new entrants →Kg , grade 2, grade 4, grade 7, grade 10 →participation in sports →working papers
The School Dr or Nurse Practitioner, does the examinations, at no charge, for students who have their physicals done in school.

_______ I request the School Doctor/Nurse Practitioner do the Physical.
_______ My child's physical will be done by our private physician: ___________________________________
* Proof of physical or appointment date must be provided within 30 days. If no response is received within 30 days, the student will have a physical with the school doctor/nurse practitioner.

SCREENINGS are done by school personnel as follows:
→Scoliosis, grades 5 through 9 →Vision: Grades Kg, 1, 2, 3, 5 ,7, 10
→Height and weight: Grades Kg, 2, 4, 7 & 10 →Hearing: Grades Kg, 1, 3, 5, 7, 10

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I understand confidential and discreet use of the above information as well as any health evaluation by the school physican will be shared as needed to meet my child's health and educational needs.

____ _______________________
Parent / Guardian signature Date