PORT JERVIS CITY SCHOOL DISTRICT

Proud Past, Bright Future

HEALTH HISTORY

School:_____

Student Name:_____ Date of Birth:_____M/F Age:_____Grade:_____
Address:_____
Physician's Name and Number:_____Fax:_____

Child lives With:
Mother's Name:_____Phone: _____
Father's Name:_____Phone:_____
Other: (Name and relationship to child)_____Phone:_____

EMERGENCY CONTACT INFORMATION:
Name:_____Relationship to child:_____
Home:_____Work:_____Cell:_____

ILLNESSES/INJURIES	Please answer Y or N for all If yes, indicate date/treatment	ILLNESSES/INJURIES	Please answer Y or N for all If yes, indicate date/treatment
ADD/ADHD		Lead Testing	
Asthma		Muscle or joint injury	
Kidney		Pneumonia	
Blood Pressure		Scarlet Fever	
Migraines/Frequency?		Scoliosis	
Concussion		Seizure disorder	
Diabetes		Sickle cell trait/disease	
Ear Infections/Frequency?		Skin Disorders	
Fainting/Dizziness		Surgery/Hospitalizations	
Fractures/broken bones		Toileting problems	
Heart problems/murmur		Tonsillitis	
Juvenile Rheum Arthritis		Thyroid Disorder	
Blood Disorder		Allergies	

Other health data:
Speech Difficulties: _____ Physical Handicaps:_____
Vision Difficulties: _____Glasses: □ Yes □ No
Hearing Difficulties: _____Hearing Aid: □ Yes □ No
High Fever:_____With Convulsions: □ Yes □ No
Menstruation: Age Began: _____ Regular □ Yes □ No Painful □ Yes □ No

Hospitalizations/Surgeries:
Reason for Hospitalization:_____Date:_____
□ Tonsils □ Appendectomy □ Hernia □Fractures □Sutures/Serious Injury
□ Other: _____

Student Name:_____ **Date:**_____

MEDICATIONS:

Name of Medication: _____ Reason:_____
Taken at home: □ Yes □ No How often?_____Dosage:_____
Taken at school: □ Yes □ No How often?_____Dosage:_____

****MEDICATION NOTE** In order for your child to receive any medication in school, over the counter or prescription, the following is required:**

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

Note: As a procedure, the school will ask parents to keep their children home from school if they show any signs of significant infections. If your child has had a fever (above 100°) he/she should not return to school until his/her temperature has been normal for at least 24 hrs.

NYS MANDATED PHYSICALS AND SCHOOL HEALTH SCREENINGS:

→ALL NEW ENTRANTS
→Pre-K or K, Gr 1, Gr 3, Gr 5, Gr 7, Gr 9, Gr 11
→participation in sports →working papers

The district supplies 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 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 done at the school.

*SCREENINGS are done by school personnel as follows: *Scoliosis -Girls Gr 5 & 7 -Boys Gr 9
*Vision/Hearing: Gr –Pre-K, K, 1, 3, 5, 7, 11 and all new entrants

*****MINIMUM IMMUNIZATIONS ARE REQUIRED BY NYS LAW AND MUST BE VERIFIED BY DOCTOR SIGNATURE OR STAMP*****

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

_____ _____
Parent/Guardian Signature **Date**

Student Name:_____ **Date:**_____

MEDICAL ALERT

Complete this section, only if applicable

Please provide the following emergency medical information to help us ensure the health and safety of your child. My child has the following medical issues that the school district should be aware of (check all conditions that apply and explain)

□ Cardiac (ex. Hypertension, heart murmur)

□ Respiratory (ex, Asthma) Diagnosed by doctor: □ Yes □ No

If yes, what type: □ Chronic □ Bronchial □ Exercise □ Other:_____

ASTHMA MEDICATION: What type of asthma treatment does your child use? Please be specific:
□ INHALER □ NEBULIZER □ PILL □ OTHER_____

□ Nervous System (ex. Seizure disorder)

□ Endocrine (ex. Diabetes)

□ Mental Health Issues (ex. Depression, anxiety, panic disorder)

If yes, what medications does your child take:_____

□ Allergies (ex. Seasonal, environmental, food medication)

If yes, which have been diagnosed/confirmed by a physician: _____

Please list all allergies and your child's reaction (be specific)

□ Food:_____
□ Lactose intolerant;_____
□ Bees/Insects;_____
□ Drugs/Antibiotic:_____

What medication/treatment does your child take for allergies?_____

Is there anything you would like to discuss with the nurse?

_____
_____

_____ _____
Parent Signature Date