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
Eye Problems
Poor vision
Poor hearing
Crossed Eyes
Tubes in ears
Frequent ear infections
Frequent headaches
Frequent nosebleeds
Frequent sore throats
High fevers
Seizures
Epilepsy
Toothaches
Dental infections
Bowel Problems
Bed wetting
Heart problems
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 _____ 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 1/07