NEW STUDENT HEALTH HISTORY
CLINTON CENTRAL SCHOOLS

75 Chenango Avenue
Clinton, NY 13323

Phone: (315)557-2238 – **High School & Middle School Fax:** (315) 557-2330 **Elementary Fax#:** (315)557-2331

NAME OF STUDENT: ______________________________ **DOB:** ________ **PLACE OF BIRTH** ________________

SEX __________ **MOTHER'S NAME:** ______________________ **FATHER'S NAME:** ____________________________

HOME ADDRESS: ____ **TELEPHONE#:** _____________

NUMBER & AGES OF SIBLINGS : ____

YES NO

1. Was your child born prematurely?
2. Did he/she have any growth or development problems as an infant or young child?
3. Does your child have any of these health problems? If so, please check and explain. (Please be specific):
   - ☐ Ear problems ____
   - ☐ Eye problems ____
   - ☐ Diabetes ____
   - ☐ Headaches ____
   - ☐ Hearing Loss ____
   - ☐ Heart Condition ____
   - ☐ Nosebleeds ____
   - ☐ Seizure disorder ____
   - ☐ Other ____
4. What medications have been prescribed for these episodes? Are the medications taken on a daily or as needed basis?
   - ☐ Medications/Drugs:
   - ☐ Foods/Plants:
   - ☐ Bee/Insect Bites:
   - ☐ Animals/Other:
   - ☐ Treatment recommended by physician for allergic response:

Is your child receiving allergy shots? ☐ YES ☐ NO
Has asthma been diagnosed by a physician? ☐ YES ☐ NO
What triggers your child's asthmatic episodes (exercise, respiratory infections, cold air, chemical fumes)?

What treatment or medications have been prescribed for these episodes are/or to be taken on a regular basis?

5. Has your child had any of the following illnesses? If yes, please give dates and explanation.
   - ☐ Chicken Pox
   - ☐ German Measles
   - ☐ Measles
   - ☐ Mononucleosis
   - ☐ Mumps
   - ☐ Pneumonia
   - ☐ Scarlet Fever
   - ☐ Strep throat/multiple infections
   - ☐ Tuberculosis
   - ☐ Tuberculosis of a family member (indicate relationship to child)

6. Please list specific severe illnesses, injuries or surgeries:

___________________________________ @ age ________________hospitalized for _______________________days
___________________________________ @ age ________________hospitalized for _______________________days
___________________________________ @ age ________________hospitalized for _______________________days

7. Does your child have any disabilities or chronic illness?

8. Does your child take any medications on a regular basis?

** If your child requires medication during the school day, please contact the school nurse regarding the school medication policy.*

9. Has your child ever been diagnosed or treated for an emotional disorder? ☐ YES ☐ NO

10. Does your child wear glasses or contact lenses? ☐ YES ☐ NO
    For what situations are glasses worn? _________________
    Are they safety plastic or polycarbonate lenses? ________________
    Date of most recent vision exam. _______________

11. Does your child have dental problems, or is he/she receiving orthodontic treatment? ☐ YES ☐ NO

12. What is the date of his/her most recent exam? ____

13. What school did your child last attend? ____

14. Was the most recently completed school year a healthy one for your child? ☐ YES ☐ NO

15. Approximately how many school days did he/she miss because of illness during the last school year? ______

16. Have you already provided the school with a record of your child's immunizations? ☐ YES ☐ NO

(A signed record from a physician or clinic, or a copy of a school immunization record, must be presented before school attendance begins. If this information is not received, New York State Public Health Law requires that your child be excluded from school.)

Signature of Parent: ____ **Date**: ______________

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.