NEW STUDENT HEALTH HISTORY
CLINTON CENTRAL SCHOOLS

75 Chenango Avenue
Clinton, NY 13323

High/Middle School Nurse Phone: (315)557-2238; **High/Middle Nurse School Fax:** (315) 557-8727;
Elementary Nurse Phone: (315-557-2258; **Elementary Nurse Fax:** (315)557-2331

NAME OF STUDENT: _____ **DOB**: _____ **PLACE OF BIRTH** _____

GENDER _____ **HOME ADDRESS:** _____

PARENT'S NAME: _____ **Telephone #** _____

PARENT'S NAME _____ **Telephone #** _____

NUMBER & AGES OF SIBLINGS _____

1. Was your child born prematurely? Yes_____ No _____
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):

☐ Breathing problems _____
☐ Ear problems _____
☐ Eye problems _____
☐ Diabetes _____
☐ Headaches _____
☐ Hearing loss _____
☐ Mental health _____
☐ Heart condition _____
☐ Nosebleeds _____
☐ Seizure disorder _____
☐ Other _____

4. Has your child been diagnosed with an allergy to any of the following:

☐ 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)?

_____

5. Has your child had any of the following illnesses? If yes, please give dates.

☐ Chicken Pox
☐ German Measles
☐ Measles
☐ Mononucleosis
☐ Mumps
☐ Pneumonia
☐ Scarlet Fever
☐ Strep throat (multiple infections)
☐ Tuberculosis
☐ Tuberculosis of a family member (indicate relationship to child)

(OVER)

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. 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. _____

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

11. What is the date of his/her most recent physical exam? _____

12. What school did your child last attend? _____

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

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

15. 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, <u>New York State Public Health Law</u> requires that your child be excluded from school.)

Signature of Parent: _____ **Date**: _____

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.