**New and Transfer Student Health History Form**

Child’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

Male \_\_\_\_\_ Female \_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Conditions**-Please check any of the following that your child currently has or has had in the past.

\_\_\_\_Abnormal Spine Curvature (Scoliosis, etc) \_\_\_\_Heart Disease, type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ADD/ADHD \_\_\_\_Kidney Disease, type \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Allergies or Hay fever \_\_\_\_Measles

\_\_\_\_Anemia \_\_\_\_Migraine Headaches

\_\_\_\_Arthritis \_\_\_\_Mumps

\_\_\_\_Asthma/Wheezing \_\_\_\_Meningitis or Encephalitis

\_\_\_\_Behavior Problems \_\_\_\_Nervous twitches/tics

\_\_\_\_Birth/Congenital Malformation \_\_\_\_Rheumatic Fever

\_\_\_\_Cancer, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Seizers of Epilepsy

\_\_\_\_Chickenpox, Date \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Sickle Cell Disease

\_\_\_\_Hepatitis \_\_\_\_Stool Soiling

\_\_\_\_Chronic Diarrhea or Constipation \_\_\_\_Substance abuse (alcohol/drugs

\_\_\_\_Cystic Fibrosis \_\_\_\_Suicide Attempt

\_\_\_\_Depression \_\_\_\_Toothaches/dental problems

\_\_\_\_Diabetes \_\_\_\_Tuberculosis (TB)

\_\_\_\_Eczema \_\_\_\_Urinary Tract Infections

\_\_\_\_Emotional Disorder \_\_\_\_Urinary Accidents (night/day)

\_\_\_\_Frequent Headaches \_\_\_\_Other Chronic Health Problems

\_\_\_\_Frequent sore throat/infections

Explain checked items\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any condition that would present full participation in educational programs (including physical education) requires physician documentation/orders before modifications can be considered. See your School Nurse for further information.**

**Allergies**-Please list and describe allergies/reactions to:

Medication/Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foods/Plants/Animals/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bee Stings/Insect Bites\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If your child requires medication for treatment of an allergic reactions during the school day, see your School Nurse for further information.**

**Injuries and Illnesses**-Please list any severe injuries or illnesses:

Illness/Injury Date(s) Hospitalized \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No\_\_\_\_\_\_\_\_\_\_

**--OVER--**

**Vision and Hearing (Check all that apply)**

\_\_\_\_Frequent Ear Infections (3 or more per year)

\_\_\_\_Hearing Loss Circle on-Right / Left / Both

\_\_\_\_P.E. Tubes (Date placed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Still in Place? Yes / No

Last Hearing Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Vision Problems

\_\_\_\_Wears Glasses / Contacts (Circle one) Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Vision Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information:**

Does your child see the doctor regularly for a chronic medical condition? (Circle One) Yes / No

If yes, please complete the following:

What is the medical condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s name AND phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are given daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are given frequently, but not daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your child last see the doctor for this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If your child requires medication during the school day (prescription or over the counter), see your School Nurse. Certain forms must be completed for medications to be dispensed during school hours.**

Doctor’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam\_\_\_\_\_\_\_\_\_\_\_Doctor/Clinic (If different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental exam\_\_\_\_\_\_\_\_\_\_\_Doctor/Clinic (If different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations received at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This child is usually: Very Active\_\_\_\_\_\_Normally Active\_\_\_\_\_\_ Passive\_\_\_\_\_\_

Do you have any concerns about how your child gets along with other children?\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have 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? If yes, explain briefly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been evaluated for:

\_\_\_\_Speech/Language Impairment

\_\_\_\_OT/PT (Occupational/Physical Therapy

\_\_\_\_LD/SLD (Learning Disability/Specific Learning Disability)

\_\_\_\_CD (Cognitive Disability)

\_\_\_\_MD (Multiple Disabilities)

\_\_\_\_ED (Emotional Disturbance)

In accordance with the Family Educational Rights and Privacy Act (FERPA) this information my be disclosed to Sherman Central School Officials (as defined by FERPA) who have a legitimate educational interest.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Please Return this Form to the Health Office\*\*\***