PORT JERVIS CITY SCHOOL DISTRICT HEALTH HISTORY

Student Full Name ____ ❑ M ❑ F Grade _________

Date of Birth___________________ Birthplace__________________________ Home Language _____________________

Student Cell Tel (if he/she has one) ____

Date entered USA, if born in foreign country____

Ethnicity *(choose one)* ❑ White ❑ Black ❑ Hispanic ❑ American Indian/Alaskan Native ❑ Asian/Pacific Islander

Home Address____ Apt. # _______

Home Tel _____________________________________ Cell Tel ____________________________

Mailing address_(if different)____

Previous School District Attended____

Previous School Address____

Has child ever attended Port Jervis Schools? ❑ Yes or ❑ No If Yes, When?__________________________________

Name of Brothers and Sisters (Last, First, Middle) ***School they attend***

____ ________________________________

____ ________________________________

____ ________________________________

Child lives with: ❑ **Both Parents** ❑ **Mother** ❑ **Father** ❑ **Guardian** ❑ **Step-Parent** ❑ **Other**____________

Parent / Guardian Name____

Address (if different)____

Relationship to student ____ Date of birth___________________________

Employer's Name____

Work Tel________________________ Cell Tel____________________________Email_______________________________

Parent / Guardian Name____

Address (if different)____

Relationship to student ____Date of birth______________________________

Employer's Name____

Work Tel________________________ Cell Tel____________________________Email_______________________________

If parent / guardian cannot be reached:

Emergency Contact ____

Address____

Relationship____

Work Tel________________________ Cell Tel____________________________Email_______________________________

Are there any **CUSTODY** issues we should be aware of? ***Be specific*** ____

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Does your child have –OR- has your child ever had any of the following (check all that apply):

❑ Eating issues ❑ weight issues ❑ head injury / concussion ❑ eye injury ❑ vision problems ❑ glasses / contacts
❑ seizures ❑ hearing problems ❑ speech problems

Does your child have FREQUENT:

❑ colds ❑ sore throats ❑ sinus infections ❑ tonsillitis ❑ headaches ❑ migraines ❑ ear infections
❑ bronchitis ❑ eczema ❑ rashes ❑ other: ____

Does your child have a history of –OR- currently being treated for any of the following:

(Please indicates dates, current treatment or medication)

ADHD___________________________ Scoliosis_________________________ Diabetes ___________________________

Thyroid problems_________________ Toileting problems________________ Kidney/Urinary problems ______________

Heart murmur____________________ Heart Disease_____________________ Blood Disorder_______________________

Broken bones/fractures_________________________ Operations____

Hospitalizations________________________________ Other: ____

When was the last time your child went to the dentist: ___________________________

ASTHMA: Does your child have asthma that has been diagnosed by a doctor? ❑ Yes ❑ No

If YES, what type: ❑ chronic ❑bronchial ❑ exercise ❑ other: _______________________________________

ASTHMA MEDICATION**: What type of asthma treatment ** does your child use? * Be Specific *

❑ INHALER ❑ NEBULIZER ❑ PILL: ___________________________ ❑ OTHER___________________________

ALLERGIES: Does your child have ANY allergies? ❑Yes ❑No known allergies

Which allergies have been diagnosed / confirmed by a doctor? ____

Please list ALL allergies and your child's REACTION *(Be specific)*

FOODS_______________________LACTOSE INTOL_______________ BEES _________________ INSECTS ______________

ANIMALS ___________________________ ENVIRONMENTAL/SEASONAL____

DRUGS/ANTIBIOTICS_______________________ OTHER____

What medication** / treatment does your child take for allergies? ______________________________________

Do you have any OTHER HEALTH CONCERNS about your child? ______________________________________

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In order for a child to receive ANY medication in school, over the counter or prescription, the following is required:

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

NEW YORK STATE MANDATED PHYSICALS AND SCHOOL HEALTH SCREENINGS:

PHYSICALS are required as follows: All new entrants; Kindergarten, Gr 2; Gr 4, Gr 7, Gr 10; 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 private 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 with the school doctor/nurse practitioner.**

SCREENINGS are done by school personnel as follows: *Scoliosis, Grades 5 through 9

*Vision: Grades Kg, 1, 2, 3, 5, 7, 10 *Height and weight: Grades Kg, 2 and 4, 7, 10 * Hearing: Grades Kg 1, 3, 5, 7,10

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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.

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Parent / Guardian Signature **Date**
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