SULLLIVAN WEST CENTRAL SCHOOL DISTRICT HEALTH OFFICE

Yearly / New Student Health History Form

Name: _____ Grade: _____

Please circle and explain below any problem your child has had:

Allergies / Seasonal; Medications, Food, Latex
Bee Sting Allergy
Asthma
Anemia
Arthritis
Bladder / Kidney Problem or Injury
Convulsions / Seizures
Fainting Spells
Diabetes
Ear Problems / Hearing Loss
Eye Problems / Vision Loss
Injury to Spleen
Joint Sprain / Ligament Tear / Muscle Pull
Elevated Blood Pressure
Night Sweats
Bloody Sputum
Headaches
Head Injury / Concussion
Heart Problem, Murmur, Chest Pain
Nose Bleeds; Frequent or Severe
Ankle Injury
Back Pain / Injury
Neck Injury
Nose Fracture
Rheumatic Fever
Stomach Ulcer
Unconsciousness or Lost Memory from a Blow

Explain_____
_____

Does your Child have any of the following?

Only One Eye or Severe Uncorrectable Loss of Vision in one or both eyes: _____

Severe Hearing Loss in both ears: _____

One Kidney: _____ One Testicle: _____

Has your child been ill for Five Consecutive Days? If Yes, explain: _____

_____

Has your child ever had an illness, condition or injury that required him/her to go to the Hospital; either as a patient overnight or in the Emergency Room for x-rays, required an operation or caused your child to miss a game or practice? If Yes
Explain:_____
_____

Is your child under Medical Care Now? If Yes, Explain: _____

Please Note: Unless you indicate otherwise, information contained on this form will be shared on a "Need to Know" basis where the safety and welfare of your child is at stake. Only relevant information will be shared such as emergency contact information, allergies and medical issues that could possible manifest themselves while the student is not in proximity to a nurse. Only teachers and staff that would be in a supervisory capacity over your child would be authorized to access this information.

_____

Has your child taken any medication in the past year? If Yes, Explain:

Why? _____

What? _____

Is your child taking medication now? If Yes, What medication? _____

Has your child ever fainted during exercise? If Yes, Explain: _____

_____

Has there ever been a Sudden Death of a Family Member under 50 years of age? _____

Do you have any worries about your child's health or other question's you would like to discuss with an R.N. or a Doctor? If Yes, What?

_____

_____

Does your child have an Orthodontic Appliance? _____

Does your child wear Contact Lenses for sports? _____

Since your child's last Physical Examination has your child had any Injury or Medical Illness? If Yes, Explain: _____

_____

Parent/Guardian Signature _____ Date: _____

New Students should return this form to the District Registrar's Office with Registration Documents.

Returning students, should return this form to the Health Office (see address below) prior to Physical Exam by School Physician or attached to Physical completed by your own Physician. Thank you for your anticipated cooperation.

Students in 7-12th Grade:

High School Health Office
PO Box 309
Lake Huntington, NY 12752
Telephone: 845-932-8401 x1120
Fax: 845-513-2601

Students in K-6th Grade:

Elementary Health Office
PO Box 308
Jeffersonville, NY 12748
Telephone: 845-482-4610 x2139
Fax: 845-482-4824