To be completed by <u>parent/guardian.</u>

2023 – 2024

PELHAM PUBLIC SCHOOLS
PELHAM, NEW YORK

PARENT HEALTH & INFORMATION SURVEY

Student _____ Date _____

Address _____ Home Phone _____

School _____ Date of Birth _____

Grade/Class _____ Place of Birth _____

Parent 1 Name _____ Parent 2 Name _____

Occupation _____ Occupation _____

Business/Cell Phone _____ Business/Cell Phone _____

Physical Exam has/will be done by Dr. _____ on _____
(Mandatory Grades K,1, 3, 5, 7, 9, 11)

Is there anything concerning your child's health that the school should know to provide necessary care?

If yes, please explain _____

Does your child wear glasses? _____ Date of last examination _____ by Dr. _____

Has your child had any illness or operations since the last school year?

If yes, please explain _____

Does your child take any medication? _____ Name/Dosage of Medication _____

Allergies to medication (type)_____ **Allergies to food** (type) _____

Allergies to environment/other _____

EMERGENCY INFORMATION

<u>Local</u> people/babysitter to be called in the case of an emergency or illness when a parent/guardian is not available:

Name _____ Home Phone _____ Cell _____

Name _____ Home Phone _____ Cell _____

Doctor to be called if necessary:

Name _____ Address _____ Phone _____

Dentist to be called if necessary:

Name _____ Address _____ Phone _____

Preexisting Dental Conditions _____

(OVER)

Has the child had any of the following? Please check and give approximate dates.

Chicken Pox _____ Asthma _____

Tuberculosis _____ Hay Fever _____

Tuberculosis in Family _____ Hives _____

Diabetes _____ Heart Condition _____

Scoliosis _____ Seizure Disorder _____

Hepatitis _____ Ear Infection _____

Blood Disorders _____

Operations/Accidents _____

Any other existing conditions or significant past medical history

_____

_____

DISTRICT MEDICATION POLICY

When a child needs to take medication at school, ALL medication MUST:

1. Be prescribed by a licensed prescriber
2. Be labeled with the child's and physician's name by the pharmacy
3. Have directions for dispensing on the bottle
4. Be accompanied by permission note from parent or guardian

Transfer of student health records: I hereby authorize the release of a copy of the student health records of my child in the event of his/her transfer to another school district.

_____

Signature of Parent/Guardian