Medical Information

Chester Elementary School
(845) 469-2178 ext. 2208
Fax # (845) 469-2794

Chester Academy
(845) 469-2231ext. 3315
Fax # (845) 469-6634

Child's Name: _____Date & Place of Birth: _____

Child's Address: _____

Child's Home Phone #: _____

Mother's Name: _____Father's Name:_____

Address: _____ Address: _____

Mother's Work #: _____ Father's Work # : _____

The New York State Department of Health has revised the regulations regarding immunization requirements for school attendance. Additional information on immunization requirements will be available on the school website shortly. If you have any questions, please contact your child's Pediatrician or the School Nurse. Thank you.

Please indicate if your child has been treated for any of the following diseases/conditions:

__ Asthma
__Chicken Pox Date: _____
__ Hepatitis
__ Pneumonia
__ Bone fracture(s)
__ Seizures
__ Frequent sore throats
__ Frequent earaches
__ Mononucleosis
__ Scarlet Fever
__ Heart Disease
Other _____

Has your child been hospitalized for any serious illness or injury? : _____

Does your child take medication regularly? Yes ____ Name of Medication _____

Does your child have allergies? _____ If yes, please list those allergies:_____

_____

Has your child received medical treatment for any allergic reaction? _____

Does your child have any medical condition that could require immediate FIRST AID? _____

Please describe: _____

Are there any special services that your child requires that the school should be made aware of? _____
_____

Does your child wear glasses? _____ Date of last eye exam: _____

Unless documentation of a Physical Examination has been provided to the School Nurse by October 1st or 30 days after entrance into school, a School Physical Examination will be conducted on your child if he/she is a new entrant or in grades K, 2, 4, 7 or 10.

Signature: _____Date: _____