RYE CITY SCHOOL DISTRICT
Health Care Services
Rye, NY 10580

NEW STUDENT HEALTH HISTORY

(To be completed by parent/guardian)

Student's Name: _____ Sex: _____ Grade: _____
Address: _____ Telephone: _____
Date of Birth: ____/____/____ Birthplace: _____
Parent/Guardian's Name: _____
Family Physician: _____ Telephone:_____
Family Dentist: _____ Telephone:_____

Health History:

Individual providing health history: _____
Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have any allergies? ❑ Yes ❑ No
If "yes", please list: _____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: _____

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No
❑ Head _____ ❑ Eyes _____ ❑ Nose _____
❑ Ears _____ ❑ Throat _____ ❑ Neck _____
❑ Chest _____ ❑ Respiratory _____
❑ Cardiovascular _____ ❑ Gastrointestinal _____
❑ Genitourinary _____ ❑ Neurological _____
❑ Musculoskeletal (include any past fractures, etc.) _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Require medication at school? ❑ Yes ❑ No
If "yes", please describe: _____

Please list any additional concerns or information: _____

_____

List any significant medical concerns in family:
❑ Mother _____ ❑ Father _____
❑ Siblings _____ ❑ Grandparents _____
❑ Other _____

Who lives with the child in his/her primary household? _____
Does child spend a significant amount of time in another household? ❑ Yes ❑ No
If "yes", please describe: _____
Who has legal custody of this child? _____
Describe any custody arrangements: _____

Any additional concerns or pertinent information (use back as needed):_____

_____

Parent/Guardian Signature:_____ Date: _____