Eden Central Schools

8289 North Main Street
Eden, New York 14057

Jeffrey A. Sortisio
Superintendent of Schools

Phone (716) 992-3629
Fax (716) 992-3656

Student Health History
(New Entrant Pre-K–12)

Student's Name_____ M___ F___Date of Birth _____

Grade _____ School Building _____

1. Does your child have/had any of the following conditions? **(Please check those that apply)**

____ Asthma (wheezes: ____occasional ____often ____only when sick ____when exercising
____ Bleeding disorder
____ Birth defect
____Chicken Pox
____ Curvature of spine (____Scoliosis ____Kyphosis)
____ Epilepsy of Seizures (____Petit Mal ____Grand Mal ____Psychomotor)
____ Gastrointestinal problems
____ Heart Condition (____Disease ____Surgery ____Murmur)
____Orthopedic Condition
Type:_____
____Pneumonia
____Premature Birth Months____ Birth weight_____
____Rheumatic Fever
____Scarlet Fever
____Urinary Problems
____At present, under care of a physician for any particular illness
____On medication
____Other

****If you checked any of the above, please complete the following:**

Explain_____

Medication_____

Special Instructions_____

Physician's name and address_____ Phone number: _____

	YES	NO	
2. Allergies	____	___	Allergic to _____
Has testing been done	___	___	Results_____
Does student carry Epi Pen	___	___	Procedure to follow if stung _____

_____

	YES	NO	DATE
3. Frequent ear infections	____	___	_____
Tubes in ear(s)	___	___	_____

Hearing loss: ___Left ____Temporary ___Permanent
___Right ____Temporary ___Permanent

-PLEASE SEE REVERSE SIDE-

	YES	NO	DATE	
4. Vision problems	____	___		Type of problem_____
Wears glasses	____	___		_____
Wears contacts	____	___		_____

	YES	NO	DATE	
5. Serious Injuries	____	___	_____	Type of injuries_____
				_____

	YES	NO	DATE	
6. Hospitalizations	____	___	_____	Reason_____
				Reason_____

	YES	NO	DATE	
7. Surgeries	____	___	_____	Type_____
	____	___	_____	Type_____

	YES	NO	DATE
8. Speech problems	____	___	_____
Speech evaluation	____	___	_____

Received speech services from_____

	YES	NO	DATE
9. Dental problems	___	___	

Wears: ___braces ___retainer ___upper ___lower

10. **IMMUNIZATION REQUIREMENTS: STATE LAW MANDATES PROOF. PRESENT PROOF AT REGISTRATION: DOCTOR'S RECORD, CLINIC RECORD, OR PREVIOUS SCHOOL RECORD.**

11. Is there anything else you would like to notify the Health Office about your child?

____YES ____NO

If yes, explain_____

_____

12. In the event of a medical emergency, and you cannot be reached, please contact:

Name_____ Phone_____

Do you give permission for this person to transport your child to the hospital? _____YES __NO

Child's doctor_____ Phone_____

Preferred hospital _____

Parent/Guardian Signature_____

Relationship to child_____ Date_____