West Seneca Central School District

Student Health History

TO BE COMPLETED BY PARENT/GUARDIAN

Name _____
(Last) (First) (Middle)

Date of Entry _____ Entering Grade _____ Birth date _____ Male/Female

Address _____
(Street) (Town) (Zip Code)

Fathers Name _____ Mothers Name _____

Student's Primary Doctor _____ Phone _____

Last School Attended? _____

Does your child	**Please circle answer**	**Comment as necessary**
1. Have allergies (insect/food/environment **CIRCLE**)?	Yes No	To what? _____
• What was your child's reaction/ANAPHYLAXIS? _____		
• How was this treated? 911, Benadryl, Epi-Pen (please circle)		
• Was this doctor diagnosed? Yes No		
• Was testing done to confirm the diagnosis Yes No		
2. Have asthma?	Yes No	How is this treated? _____
History of lung disease?	Yes No	
3. Have frequent sore throats/strep throat?	Yes No	
4. Have frequent stomach aches?	Yes No	Describe _____
5. Have ear problems/tubes/loss of hearing?	Yes No	Describe _____
6. Wear glasses or contact lenses? (Please circle)	Yes No	Date of last exam _____
7. Have an orthopedic/bone/joint problem?	Yes No	Describe _____
8. Have frequent headaches?	Yes No	Home Treatment _____
9. Have fainting spells?	Yes No	Describe _____
10. Have a seizure disorder/staring spells?	Yes No	Comment on reverse side
History of concussion?	Yes No	
11. Have diabetes?	Yes No	Comment on reverse side
12. Have a heart condition, chest pain?	Yes No	Describe _____
Family history of sudden death (cardiac/heart)	Yes No	Family member _____
13. Have kidney or bladder problems?	Yes No	Describe _____
14. Have anemia or other blood disorder?	Yes No	Describe _____
15. Have any skin conditions?	Yes No	Describe _____
16. Have scoliosis?	Yes No	
17. Wear dental braces?	Yes No	

Rev 2/2015

PLEASE COMPLETE THE REVERSE SIDE

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Has your child ever been hospitalized for tests, illness, surgery? Explain if yes _____

_____

Has your child ever been treated for serious injuries or fractures? Explain if yes _____

_____

_____

Does anyone at home have a medical problem? Explain if yes _____

_____

Are there any special problems or conditions we should know about to better understand your child? Explain if yes _____

_____

Does your child take any medication at home? _____

Will it be necessary for your child to take medication in school? Explain _____

_____ **(See nurse for medication regulations).**

STUDENTS ENTERING UPK THROUGH 6TH GRADE
PLEASE COMPLETE THE FOLLOWING:

GROWTH AND DEVELOPMENT OF YOUR CHILD

Birth weight _____ Premature birth? Yes No
Age at which your child: Walked _____ Toilet trained _____

STUDENTS ENTERING 7TH THROUGH 12TH GRADE
PLEASE COMPLETE THE FOLLOWING:

Does your child know how to swim? Yes No

Does your child have any medical restrictions that would prevent full participation in a swim program? Yes No
Explain if yes _____

IF YOU WISH TO HAVE A CONFERENCE WITH THE SCHOOL NURSE, PLEASE CHECK HERE _____

Additional Comments: