SCHUYLERVILLE
CENTRAL SCHOOL DISTRICT

(518) 695-3255
Elementary School Nurse: ext. 1220
Middle School Nurse: ext. 2293
High School Nurse: ext. 2244

Student's Name ______________________________ DOB _______________ Sex: M / F Grade: ______

Address ______________________________ Phone Number ___________ Birthplace _______________

Father's Name ________________Employer ________________ Phone ____________ Cell: __________

Mother's Name _______________Employer ________________ Phone ____________ Cell: __________

With Whom Does the Child Reside ____

Please indicate if your child has had the following illnesses or conditions (if so, please list dates):

Anemia ________	Chicken Pox ________	Kidney Problems ________	Contact with TB ________
Asthma ________	Pneumonia ________	Diabetes ________	Mumps ________
Epilepsy ________	Heart Murmur ________	Rheumatic Fever ________	German Measles ________
Tuberculosis ________	Heart Disease ________	Whooping Cough ________	Measles ________

Other Preventive Measures

1. Is your child currently taking medication? YES ____ NO____
   Name _____________________________________ Dosage Required _______________________
   For what reason? ____

2. Does your child have any allergies which require attention at school? YES ____ NO____
   Please list specific instructions for allergic reactions, especially for bee stings or food allergies:
   ____
   *Please provide recommendations in writing from your physician for treatment of allergy
   Describe type of reaction ____
   Name of Physician ____

3. Have you ever suspected that your child may have a problem hearing? YES ____ NO____
   If so, has your child ever had their hearing tested? YES ____ NO____
   If so, what was the result of the examination and recommendation, if any?
   ____
   Name of examiner ____

4. Have you ever suspected that he/she may have a vision problem? YES ____ NO____
   Has your child ever been seen by an optometrist or eye specialist? YES ____ NO____

If so, what was the result of the examination and recommendations, if any?

____

Name of examiner ____

5. Has your child had any other screenings for medical evaluation? YES ____ NO____
   If yes, what were the results? ____
   Name of Physician ____

6. Has your child been hospitalized at all since birth? YES ____ NO____ DATE _____________
   If so, what was the reason? ____
   Was your child born prematurely? YES ____ NO____ How many weeks premature? __________

7. During the past year, has your child had an illness, serious injury or operation? YES ____ NO____
   If yes, please describe it: ____
   Is your child still under treatment? YES ____ NO____
   Name of Physician ____

8. Has your child ever seen a dentist? YES ____ NO____ DATE ___________________
   If so, for what reason? ____

9. Should your child be restricted from participating in school sports or gym? YES ____ NO____
   If yes, please provide recommendations from physician in writing.

10. Have there been any changes in your family during the past year such as:
    Separation, divorce or remarriage? YES ____ NO____
    Death or serious illness? YES ____ NO____
    Or any other situation which may affect your child? YES ____ NO____

    If yes, please explain ____

11. Any additional information or comments you would like to share regarding your child

    ____

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12. A current physical examination is required for all new enterers. Please check one:
    _________ A physical examination has recently been done by a physician licensed in New York State and a copy will be provided to the school nurse.
    _________ A physical examination may be done by school physician.

***********************PLEASE ATTACH A COPY OF IMMUNIZATIONS ***********************

I understand that all reports and testing results will be treated confidentially.

_________________________ _________________________

Date *Parent Signature*