

SCHUYLERVILLE
CENTRAL SCHOOL DISTRICT

(518) 695-3255
Elementary School Nurse: ext. 1229
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 ___

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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 (resistance to eating certain items, toileting concerns, fears of any kind, etc.)

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12. A current physical examination is required for all new entrants. 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