SCHUYLERVILLE
CENTRAL SCHOOL DISTRICT

(518) 695-3255
Elementary School Nurse: ext. 1228 & 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):

Asthma________	Concussion (Dates) ____	COVID (Dates) __________	Diabetes_____________
Heart Disease* _____	Heart Murmur*_______	Kidney Problems______	Physical Disability*_____________
Seizure Disorder________	Tuberculosis__________	Whooping Cough________	Other* ________________

*Please give further information____

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. Is there a history of cardiac issues in the family? If so, please explain:

    ____

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

    _________A copy of 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 has been scheduled with a physician licensed in New York State. Date of physical: _______________________________

    Name and phone number of physician: ____

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

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

________ ***I give permission for my child to be seen by the school physician if needed.***

________________________ ________________________

Date *Parent Signature*