West Seneca Central School District

Student Health History

Parent/Guardian Please Complete

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

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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 Grade 6

Growth and Development of your Child

Premature birth? Yes No Birth weight __________

Age at which your child: walked _______ toliet trained ________

Students Entering Grades 7 through 12

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 ____

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Additional Comments:

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If you wish to have a conference with the school nurse, please check here ❒