ENTERING HEALTH HISTORY
CONFIDENTIAL INFORMATION

LAKELAND CENTRAL SCHOOL DISTRICT
SHRUB OAK, NEW YORK

ENTERING GRADE ________________
TO BE COMPLETED BY PARENT/GUARDIAN

NAME____SEX M______ F______BIRTHDATE____________BIRTHPLACE______________

ADDRESS____ HOME PHONE ( )_____________________________

FATHER'S NAME_________________________HOME ( )________________ WORK ( ) ____________CELL ( )_____________________

MOTHER'S NAME_________________________HOME ( )________________ WORK ( ) ____________CELL ( )____________________

Child resides with: ____

EMERGENCY – PERSON TO CONTACT if parent is not available.

(1) NAME__________________HOME ( )__________________ WORK ( )__________________ CELL ( )__________________

Is child covered by health insurance? _______ Yes _________ No

Physician____________________Phone ( )_________________________Dentist ______________________________Phone ( )____________

New York State Education Law and New York State Public Health Law requires for all students will be properly & completely immunized in accordance with the law at the time of admission. A signed and stamped copy of immunization by your Health care provider must be presented to the school before entering. http://www.schoolhealthservicesny.com/files/filesystem/ImmunizationRegulationRevisions.pdf *

Has your child resided outside the UNITED STATES for more than TWO (2) months? YES________ NO________

If yes where? ___________________

TO BE COMPLETED BY PARENT/GUARDIAN **Assessment of Student's Health History**

To the best of your knowledge, has your child had any problem with the following? Please check **Yes** or **No**.

Condition	Yes	No	Comment if "Yes"
Allergy __ food __ Insect __Latex __ ____ medication ____ seasonal ____ other			Specify allergen(s): ________________________ Specify previous symptoms: ________________________
Has the allergy required emergency treatment?			Treatment Prescribed: ________________________
History of anaphylaxis			History of anaphylaxis: last occurrence__________.
Asthma or breathing problems ___ Intermittent or _______Persistent			Quick relief inhaler ____ Yes NO ______ Asthma Action Plan _____ Yes NO ______
Attention-Deficit/Hyperactivity Disorder			
Behavioral/Developmental problems			
Bladder and/or bowel problems			
Bleeding problems			
Cerebral Palsy			
COVID-19: Has your child ever tested positive?			
Cystic Fibrosis			
Dental Problems			* Date of last dental visit *
Diabetes			
Head or spinal injury			
Hearing problems or deafness			
Heart problems			
Hospitalizations / Surgery (reason/ date)			
Lead poisoning			
Lyme disease			
Musculoskeletal problems			(include any past fractures, etc)
Seizures / Seizure Action Plan			Date of last seizure ______
Sickle Cell Disease (not trait)			
Speech Problems			
Stomach /Nutritional issues			
Vision problems/ eye glasses			

List all prescription and over-the-counter medications your child takes regularly: ____

TO BE COMPLETED BY PARENT/GUARDIAN

Describe any other important health-related information or concerns about your child (i.e., feeding tube, oxygen support, hearing aid, etc.):

____

DEVELOPMENTAL HISTORY: Delivery: _______________ Term: _________ Birth Weight_______/ Length: __________

Condition at birth: ___________ Cyanosis: _____ Jaundice: ______ Feeding Habits: _______________ Bladder_________ Bowel__________

Indicate approximate age for the following: SAT UP______ STOOD______ WALKED________ SENTENCES_______ TEETH_______

Name of Nursery School or Previous School ____

Signature of Parent or Legal Guardian: ____**Date:** __________________

Please note: A physical exam must be provided within 30 days of entrance. Students who do not return evidence of a physical exam will have a HEALTH APPRAISAL scheduled with our Medical Director.