Andes Central School

Health History

Child's Name ___________________________________Date of Birth ____________________________

Family Dentist _________________________________ Address ________________________________
Phone ____________________________ ________________________________

Is your child presently undergoing dental treatment? ❒Yes ❒No Last appointment ____________________
Explain ____

Health Care Provider ____________________________ Address ________________________________
Phone ____________________________ ________________________________

Has your child had a complete physical exam? ❒Yes ❒No Date __________

Has your child ever had a complete eye exam? ❒Yes ❒No Date __________ Glasses? ❒Yes ❒No

Is there anything regarding the eyes/vision, ears/hearing, oral/dental, or general health of your child that the school should know about in order to provide the care and understanding of your child?_______________
____
____

Is your child **allergic** to anything (medications, foods, insects, etc): ❒ NKA or-_____________________________
Please describe the reaction:____

Does your child take medications regularly? ❒Yes ❒No

If Yes, will it be necessary for him/her to take this medication during school hours? ❒Yes ❒No
What is the medication? ____
Why does your child take the medication? ____

Has your child ever had: *Please check any that apply*

❒ Asthma	❒ Concussion	❒ Anemia	❒ Diabetes	❒ Chickenpox
❒ Dizzyness	❒ Fainted	❒ Pneumonia	❒ Pertusis (Whooping Cough)	
❒ Rheumatic fever	❒ High fevers	❒ Seizures	❒ Ear infections	❒ Strep throat
❒ Nosebleeds	❒ Arthritis	❒ Heart disease	❒ Cancer	❒ Chronic illness
❒ Hernia	❒ Heart murmur	❒ Headaches	❒ Scarlet fever	❒ Eczema
❒ Hepatitis	❒ Hemophilia	❒ Mononucleosis	❒ Bowel problems	❒ Kidney disease
❒ Urinary frequency	❒ Urinary problems	❒ Stomach problems	❒ Prolapsed Mitral Valve	
❒ Serious Injuries/Trauma		❒Serious Illnesses	❒ Painful joints/walking problems	
❒ Orthopedic problems	❒ Hospitalization	❒ Operations: ______________________________		

Other ____

Please provide information for any box checked:____
____
____

Can your child participate fully in **all** school activities? ❒Yes ❒No
If No, explain ____

Has your child had any experiences which might influence his/her emotional, social, or physical development?
❒Yes ❒No Explain ____

History: Are there any of these medical factors present in this child's history which may have affected growth and/or development?
Family ____
Pregnancy complications ____
Labor/Delivery ____
Neonatal ____

Has your child:
- Attended pre-kindergarten or nursery school programs? ❒Yes ❒No
- Experienced frequent changes of residence? ❒Yes ❒No
- Experienced death of a family member? ❒Yes ❒No
- Experienced an accident? ❒Yes ❒No
- Experienced a fire? ❒Yes ❒No
- Have a fear of something? ❒Yes ❒No

Other, explain ____

Please provide the school district with (1) a copy of your child's birth certificate, and (2) the child's immunization record signed by health care provider.

My signature on this form indicates that I understand medical information will only be shared with other school staff on a "need to know" basis.

Parent's Signature ______________________________ **Date** ____________________

Office Use Only:

___ Birth Certificate

___ Physical Exam
School / HCP

___ Immunization Record

___ Health History Reviewed

New York State Immunization Requirements for School Entrance/Attendance		
PreK ❑ DTaP 4 doses ❑ Polio 3 doses ❑ Hep B 3 doses ❑ Hib 1 dose ❑ MMR 1 dose ❑ Varicella 1 dose ❑ PCV 1 dose	**K** ❑ DTP/DTaP 4 doses ❑ Polio 3 doses ❑ Hep B 3 doses ❑ MMR 1 doses ***2 doses by 7 y/o*** ❑ Varicella 2 doses	**1-5** ❑ DTP/DTaP 4 doses ❑ Polio 3 doses ❑ Hep B 3 doses ❑ MMR 2 doses ***by 7 y/o*** ❑ Varicella 1 dose
6 ❑ DTP/DTaP 3 doses ❑ Tdap- 1 dose ***by 11y/o*** ❑ Polio 3 doses ❑ Hep B 3 doses ❑ MMR 2 doses ❑ Varicella 2 doses	**7-12** ❑ DTP/DTaP 3 doses ❑ Tdap- 1 dose ❑ Polio 3 doses ❑ Hep B 3 doses ❑ MMR 2 doses ❑ Varicella 1 doses	