St. Stephens Parochial School ~ Grand Island CSD
School Health Services
Confidential Health History

Dear Parent or Guardian, Date:__________

Please complete these forms in their entirety, to enable us to complete a cumulative health record for your child. This information is confidential and will be shared only with appropriate school personnel.

Student Name:______________________________ Grade: ________ Birthdate:_______

Address:__________________________________ Sex: ☐ M ☐ F Birthplace:_______

____ Telephone: ________________

Did this student previously attend a Grand Island School? ☐ Yes ☐ No

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It is necessary that the school permanent records contain current information on the following:
Child lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _________

Father/Stepfather's Name: ____________________________ Birthplace:____________
Place of Employment:________________________________ Occupation:____________
Work Telephone:____________________________________

Mother/Stepmother's Name: ___________________________ Birthplace:____________
Place of Employment:________________________________ Occupation:____________
Work Telephone:____________________________________

Physician's Name:____________________________________ Telephone:___________

Dentist's Name:______________________________________ Telephone:___________

In case of emergency (illness or injury) and we are unable to contact you, please give the name of the person or persons you have made arrangements with who will assume responsibility for your child:

Name:____ Relationship to Child:___________
Address:____ Telephone:___________

Name:____ Relationship to Child:___________
Address:____ Telephone:___________

Birth Weight:__________ Any special care or treatment shortly after birth? ☐ Yes ☐ No
If yes, please explain____

Does your child require special shoes, braces, crutches, wheelchair, diet medication, or have impaired function? ☐ Yes ☐ No
If yes, please explain____

Any serious illnesses or hospitalizations? ☐ Yes ☐ No How long?__________ When:_____

Does your child have any congenital abnormalities or defects? ☐ Yes ☐ No
If yes, please explain____

STUDENT'S HISTORY: *(Please check all that apply)*

☐ Head Injury ☐ Loss of Consciousness ☐ Concussion ☐ Skull fracture

☐ Frequent headaches ☐ EEG, CT Scan or MRI:

Describe____

☐ Heart Murmur ☐ Heart Disease ☐ Chest Pain ☐ Shortness of breath ☐ EKG

Describe____

☐ Asthma ☐ Reactive Airway Disease ☐ Breathing or Lung Problems

Describe____

Has student ever been, or currently being followed by a doctor or clinic for any health problems:

☐ Yes ☐ No If yes, please describe:______________________________

Is there any mental, emotional, or physical condition the school should know about?

☐ Yes ☐ No If yes, please describe:______________________________

Does this student have any known allergies? (e.g. Insects, pets, food, seasonal, environmental….)

☐ Yes ☐ No If yes, please describe:______________________________

Does this student require any emergency medication for a severe allergy? ☐ Yes ☐ No

If yes, please describe:____________________________________

Is this student currently taking any medication on a regular basis? ☐ Yes ☐ No

If yes, for what reason?____________________________________

Name and Dosage:____

Is it necessary for school? ☐ Yes ☐ No

STUDENTS HISTORY: *(Please give dates and explanation if necessary)*

	DATE	EXPLANATION
Anemia		
Chickenpox		
Hard to stop bleeding		
Nose bleeds		
Diabetes		
Epilepsy		
Heart Disease		
Hepatitis		
Nephritis		
Pneumonia		
Rheumatic Fever		
Scarlet Fever		
Strep Throat		
Mononucleosis		
Dental Caps, Braces / Plates		
Migraine Headaches		
Sinus Infections		
Menstrual Problems		
Joint Problems		
Bladder Problems		
Asthma		
Bronchitis		
Frequent Colds		
Ear Conditions		
Fainting Spells		
Convulsions / Fits		
Staring spells		
Fractures / Broken bones		
Operations		
Serious injury		
Stitches (include location)		
Scoliosis		
Vision Problems		
Glasses		
Eye Patched		
Eye Exercises		
Amblyopia / weak muscles		
Hearing problems		
Loss		
Wears Aids / Uses FM System		
Tubes		

FAMILY HISTORY: *(Please check all that apply)*

	CHECK	RELATIONSHIP TO CHILD
Asthma		
Allergies		
Cancer		
Diabetes		
Seizure Disorder		
High Blood Pressure		
Stroke		
Low Blood Sugar		
Migraines		
TB		
Heart Attack before age 50		
Hereditary Disease		

ADDITIONAL COMMENTS:

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Signature Parent / Guardian:________________________________ Date__________

All new students are required by New York State Law to have a physical examination.