OFFICE USE

PROOF OF IMMUNIZATION:

Document:
Date Seen: By:

LEGAL REQUIREMENTS WAIVED:

___Parent's religion
___Physician's cert.

UNION-ENDICOTT CENTRAL SCHOOL DISTRICT

HEALTH SHEET FOR NEW ENTRANTS

Name of Child ______________________ Date of Birth ______________________

Your Name ______________________ Relationship to Child ______________________

IMMUNIZATIONS, TESTS, ETC. Required by N.Y. S. Law

Please provide original document of immunizations (shots)

PREGNANCY/BIRTH HISTORY	YES	NO	If "yes", explain (including dates/or age of child)
Did mother have any health problems during this pregnancy or delivery?			
Was child born more than 3 weeks early or late?			
Was child less than 5 lbs. or more than 10 lbs. at birth?			
Was anything wrong with child in the hospital nursery?			
Did child or mother stay in hospital longer than usual for medical reasons?			

HOSPITALIZATIONS AND ILLNESSES	YES	NO	If "yes", explain (include dates/or age of child)
Has child ever been hospitalized or had surgery?			
Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning, or car accident)?			
Has child ever had a serious illness?			

(Please continue on reverse side....)

HEALTH SHEET FOR NEW ENTRANTS, CONT.

HEALTH PROBLEMS	YES	NO	If "yes", explain (including dates/or age of child)
Does child have frequent sore throats?			
Does child have frequent cough?			
Does child have frequent urinary infections or trouble urinating?			
Does child have frequent stomach pain, vomiting, or diarrhea?			
Does child have difficulty seeing (squint, cross eyes, look closely at books)?			If "yes", was last checkup more than one year ago?
Is child wearing (or suppose to wear) eye glasses?			
Does child have problems with ears/hearing (pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?			
Has child ever had a convulsion or seizure?			If "yes", when did it last happen?
Is child taking medicine for seizures?			What medicine?
Is child taking any medication now? (Special consent form must be signed to administer any medication at school.)			What medicine? If "yes", will it need to be given at school? How often?

Who is your child's Doctor? ____________________ Dentist? ____________________

Is child now being treated by a physician and/or dentist? If yes, what for? ____________________

Has child had: when?

_____ Chickenpox _____
(Date of occurrence must be documented by physician)
_____ Eczema _____
_____ German Measles _____
_____ Measles _____

when?

_____ Mumps _____
_____ Scarlet Fever _____
_____ Whooping Cough _____
_____

Has child had: when?

_____ Asthma _____
_____ Diabetes _____
_____ Heart/Blood vessel disease _____
_____ Pneumonia _____
Tuberculosis

when?

_____ Bleeding Tendencies _____
_____ Epilepsy _____
_____ Liver Disease _____
_____ Rheumatic Fever _____
Sickle Cell Disease

If "yes," please explain:

Does child have any allergy problems (rash, itching, swelling, difficulty breathing, coughing, sneezing?

	what:	reaction:
with food…		
with medication…		
with environment…		
ex.: dust, insects, etc.		

Parent/Guardian Signature: ____________________ Date: ____________________