Student's Name: ____ Date of Birth: ________________
Name of individual providing information: ____________________________ Date: ________
Relationship to child: ________________________

DeRuyter Central School
Health History Form

Student's Name: ____DOB______________Male/Female

Mailing Address: ____

____

City/State of Birth:____________________________________ Hospital: ____________________________

Father's Full Name: __________________________________ Home Phone: (_____) ______-__________

Address: ____ Cell Phone: (_____)______-____________

____ Work Phone: (_____) _____-___________

Employer: ____

Mother's Full Name: ___________________________________ Home Phone: (_____) ______-__________

Address: ____ Cell Phone: (_____)______-____________

____ Work Phone: (_____) _____-___________

Employer: ____

Parental Status: (Circle one) Married Separated Divorced Single Co-habitating

Please list anyone else involved in caring for/making decisions for this child. (i.e. legal guardian, step-parent)
Name Contact Information Relationship

____

____

____

Siblings Attending DeRuyter Central School:
Name Grade

____

____

____

Pregnancy/Birth History

1. Were there any issues during pregnancy, labor and/or delivery for this child, or mother? Yes No
   If yes, please describe: ____
2. Was child born more than 3 weeks early or late? Yes No
   If yes, please describe: ____
3. What was the child's birth weight? _____pounds _____ounces
4. Were there any issues with this child in the nursery? Yes No
   If yes, please describe: ____
5. Did this child or mother stay in the hospital for medical reasons longer than usual? Yes No
   If yes, please describe: ____

Student's Name: ____ Date of Birth: ________________
Name of individual providing information: ___________________________ Date: ________
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Health History

6. Does this child have an ongoing health concern? (asthma, diabetes, etc) Yes No
   If yes, please describe: ____

7. Is there a history of any hospitalizations, significant injuries or surgery? Yes No
   If yes, please describe: ____

8. Are there any current concerns/injuries: Yes No

- ❑ Head _______________________________
- ❑ Eyes ______________________________
- ❑ Throat ______________________________
- ❑ Skin ______________________________
- ❑ Speech _____________________________
- ❑ Chest ______________________________
- ❑ Cardiovascular ______________________
- ❑ Genitourinary ______________________
- ❑ Ears ____________________________________
- ❑ Nose ____________________________________
- ❑ Neck ____________________________________
- ❑ Teeth ____________________________________
- ❑ Hearing __________________________________
- ❑ Respiratory ______________________________
- ❑ Gastrointestinal ___________________________
- ❑ Neurological _____________________________
- ❑ Musculoskeletal (include any past fractures, etc.) _______________________________________
- ❑ Emotional/Behavioral ____

9. Does this child wear glasses? Yes No

10. Has this child's lead level been tested? (Usually done at 1 or 2 years of age) Yes No
    If no, please follow up with your child's primary healthcare provider.

11. Does this child have any allergies? Yes No
    If yes, please list allergen and reaction: ____

12. Does this child take any medication regularly at home? Yes No
    If yes, please list medications: ____

13. Does this child require any medication at school?* Yes No
    If yes, please list medications: ____

*** Any medication which needs to be given during school, including rescue inhalers and epi-pens, requires a primary care provider's order and written permission from a parent/guardian, see DeRuyter Central School Parent and Prescriber's Authorization for Medication Administration in School Form included in this packet.**

14. Please list any additional concerns or information: ____

____

15. Describe child's nutritional pattern and dietary intake: ____

____

16. List any significant medical concerns in family:

- ❑ Mother _________________________________
- ❑ Siblings ________________________________
- ❑ Father _________________________________
- ❑ Grandparents ____________________________
- ❑ Other ____

17. Is this child now being treated by a physician/dentist? Yes No

    Physician's Name: ____ Phone: ________________

    Address:____

    Dentist's Name: ____ Phone: ________________

    Address: ____

Student's Name: ____ Date of Birth: ________________
Name of individual providing information: ___________________________ Date: ________
Relationship to child: ________________________

Developmental Milestones

18. Has this child reached developmental milestones at the appropriate age range?

Developmental Milestone	General Age Range Reached		
Sits up with out help	5-12 months	Yes	No
Crawls	6-12 months	Yes	No
Walks	9-18 months	Yes	No
Talks (single word "mama" of "dada")	9-12 months	Yes	No
Feeds self, finger foods	9-12 months	Yes	No
Toilets	2-5 years	Yes	No

If no, please explain: ____
____

Please return this form along with a copy of your child's proof of immunizations, New York State Immunization Registry preferred, to the school nurse. DeRuyter Central School can not allow a student to attend school without the required immunizations, see New York State Immunization Requirements for School Entrance/Attendance included in this packet.

By affixing my signature to this form I am agreeing to allow the school nurse to share information with school staff to ensure the health and safety of my child. (For example: food allergies, bee sting allergies, seizure, disorder, etc.)

Signature of Parent/Guardian: ____ Date: _________________