Bethlehem Central School District
Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481

HEALTH HISTORY FOR NEW ENTRANTS

This form should be completed and signed by the parent or guardian

Home School *(Please circle one)* CLK EAG ELS GLE HAM SLI

Name ______________________________ DOB ____________________

Family Physician ______________________________ Phone ____________________

Last visit to M.D. *(date, reason)* ____________ Date of last physical ________ Next M.D. visit *(date, reason)* ______________

Dentist ______________________________ Phone ____________________

Pregnancy History (gestational diabetes, bed rest, medication needs)

____

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital): ______________________

____

Gestation: _____ Full term _____ Premature Delivery: _____Normal _____ Cesarean Birth Weight: ____________

Growth and Development / Walked at age: ________ Spoke first word at age: ________ Spoke sentences at age: ________

Health History

Serious illness: ____

Serious injury: ____

Surgery: ____

Check if your child has, or has had, any of the following and provide date when appropriate:

_________ Allergies
- ________ Bee sting
- ________ Food
- ________ Medication
- ________ Other

_________ Anemia
_________ Asthma
_________ Cerebral Palsy
_________ Chicken Pox *(documentation)*
_________ Colds & Sore Throats
_________ Convulsions
- ________ With fever
- ________ Without fever

_________ Cystic Fibrosis
_________ Diabetes

_________ Ear Infections
- ________ History of PE Tubes

_________ Eye Conditions
_________ Hearing Problem
_________ Heart Disease
_________ Hypotonia
_________ Kidney Disease
_________ Learning Disabilities
_________ Leukemia
_________ Measles
_________ Mononucleosis
_________ Mumps
_________ Orthopedic Conditions
_________ Pneumonia

_________ Rheumatic Disease
_________ Rubella Disease
_________ Scarlet Fever
_________ Seizure Disorder
_________ Speech Problem
_________ Strep Throat
_________ TB
- ________ Chest X-ray

_________ Urinary Infections
_________ Urinary Reflux
_________ Vision Problem
- Last Vision Exam:
- Vision Specialist:
- Glasses Worn: YES NO

_________ Whooping Cough

Current Health Status (Please state if your child is, or has been, under treatment, or taking medication:

Health conditions under treatment: ______________________________________

Medical provider(s) providing treatment: ______________________________

Medication(s) prescribed: ______________________________________

Will medications need to be given while your child is at school?

_________ Yes ________ Not known at this time

Are the any physical restrictions or limitations for physical education or other activities at school?

_________ Yes _______ No *** If restrictions or limitations, M.D. documentation is required**

Has your child ever received, or is currently receiving, the following services:

________ OT ________ PT ________ Speech ________ Other

______________________________________ ____________________

Parent/Guardian Signature *Date*