

Croton-Harmon School District Annual Health Information Update

Student's Name: _____ Grade/Teacher: _____ D.O.B. _____

Address: _____ Home Tel. # _____

Mother's Name: _____ **Father's Name:** _____

Home Phone: _____ Home Phone: _____

Business Phone: _____ Business Phone: _____

Cell Phone: _____ Cell Phone: _____

List relatives or friends who are available to come for your child in case of illness or injury, when family cannot be reached.
(VERY IMPORTANT)

Name: _____ Tel.#: _____

Name: _____ Tel.#: _____

Student's Physician: _____ Tel.#: _____

Student's Dentist: _____ Tel.#: _____

Permission to contact above, if necessary _____

(Signature of Parent or Guardian)

Current Health Information

During the past year, has student had:
Injuries? (State body part, right or left) _____ Tetanus shot given? _____

Serious Illness, disease, or operation? _____

Date of last eye exam _____ Doctor's Name _____

Are glasses necessary? _____ If so, when? Help student see close _____ Help student see far _____ Other _____

Allergies? List and describe reaction _____

Bee sting? _____ If yes, oral medication _____ injection _____ hospital _____

Asthma? _____ Triggers _____ Treatment _____

Is student taking any medication? _____ Reason _____

Name of medication _____ How much _____ How often _____

Is student experiencing any side effects from medication that we should be aware of? _____

(Medications cannot be given to a student in school without written parental permission and a written doctor's order.)

Is there any other information about your child that the school health services should be aware of? _____

I understand that this information may be shared with school staff on a need-to-know basis.

New York State Requires That Each Child Receive A Physical Exam In The Following Grades:
Kindergarten, 2nd, 4th, 7th and 10th. Check one of the following **ONLY** if your child is in one of these grades.

_____ Student had a physical exam during the summer, and the completed form has been returned to school.

_____ Student will be examined by Dr. _____ on _____

_____ I understand that if the completed form is not returned by October 15th, it will be assumed that I wish Dr. Belkin, School Physician, to examine my child in school.

(Date) Signed: _____
(Signature of Parent or Guardian)