CONFIDENTIAL

Plattsburgh City School District
Thomas E. Glasgow/Oak Street/Arthur P. Momot
Elementary Schools New Student Health History

STUDENT NAME: _______________________________ DOB: _________ GRADE/TEACHER: ____________

MEDICATIONS (List name, dosage and times of any medication your child currently takes)

Medication Name	Dosage	Times Administered
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ASTHMA: Yes/No (circle one)

Medications/inhaler: 1. ____________________________ taken: daily/weekly/month (circle one)

2. ____________________________ taken: daily/weekly/month (circle one)

My Child Can Use Alcohol Based Hand Sanitizer: Yes/No (circle one)

SIGNIFICANT MEDICAL HISTORY

Accidents/Serious Injuries	Date	Problem
1.		
2.		
3.		
Hospitalizations:	**Date**	**Problem**
1.		
2.		
3.		
Serious/Chronic/Long term Illness or Diagnosis:	**Date**	**Problem**
1.		
2.		
3.		
4.		

ALLERGIES (Identify and describe reaction to any of the following):

Food ____________________________________	Symptom__________________________________
Drug/Medication ___________________________	Symptom__________________________________
Bee/Insect Sting ___________________________	Symptom _________________________________
Seasonal/Environmental ____________________	Symptom _________________________________

PLEASE CONTINUE TO THE OTHER SIDE

CONFIDENTIAL

Student Health History (continued)

*****Please answer each question below and provide details for any "yes" responses on bottom of page.*****

Has student ever experienced…	Yes	No
• A serious head injury/concussion		
• Loss of consciousness		
• Eye/vision difficulties		
• Multiple ear infections		
• Tubes in ears		
• Hearing loss		
• Multiple strep infections		
• A heart murmur		
• Congenital heart disease		
• Rapid heartbeat/ palpitations		
• asthma		
• bronchitis/pneumonia		
• cystic fibrosis		
• kidney disease		
• bladder/urinary tract infections		
• enuresis (bed wetting)		
• encopresis (fecal soiling)		
• constipation		
• hernia		
• undescended or one testicle		
• weight concerns		
• Emotional problems (stress, anxiety, or depression)?		

Has student ever experienced…	Yes	No
• diabetes		
• any communicable disease (chickenpox, hepatitis, whooping cough, tuberculosis, mono)		
• fever greater than 103 F		
• developmental delays (in speech, movement, or learning)		
• skin conditions (like eczema, psoriasis)		
• allergies		
• seizures		
• staring spells		
• joint pain/swelling		
• limitation of movement		
• fractures		
• braces/adaptive equipment		
• poor coordination		
• attention concerns		
Does student….	Yes	No
• Wear glasses?		
• Use hearing aids?		
• Have an orthodontic device (braces, retainer)?		
• Have special dietary needs?		

Additional comments (please explain any "yes" answers above):

____

____

Student's Primary Healthcare Provider____

Parent/Guardian Signature________________________________ **Date** ______________

I, parent/guardian of ________________________________DOB: __________do hereby give permission for the school nurse at Thomas E. Glasgow/Oak/Arthur P. Momot Elementary to communicate with my child's primary health care provider regarding medications, physical exams, immunizations, and other health issues, for the current school year. I understand that this consent may be revoked at any time.

____ ________________

Parent/Guardian Signature **Date**

CONFIDENTIAL

Plattsburgh City School District
Thomas E. Glasgow/Oak Street/Arthur P. Momot Elementary Schools
DEVELOPMENTAL HISTORY

(to be completed for new students)

STUDENT NAME: ______________________ DOB: _________ GRADE/TEACHER: ____________

PREGNANCY INFORMATION:

Mother's Age during pregnancy: _________ Length of Pregnancy (in weeks): ________________

CONCERNS DURING PREGNANCY (check any that apply)

◯ Infection ◯ Bleeding ◯ High Blood Pressure ◯ Anemia ◯ Trauma
◯ Inherited Disease ◯ Medication (other than iron, vitamins) ◯ Chronic Disease
◯ Hospitalization ◯ Swelling ◯ Other ___________________________________

LABOR AND DELIVERY:

Length of labor: _______ hours

Delivery complications (check all that apply)

◯ Cesarean ◯ Forceps ◯ Breech ◯ Slowed heartrate

Anesthesia/medications given during delivery? ◯ No ◯ Yes __________________

NEONATAL:

Birth Weight: ____lbs ____oz

COMPLICATIONS (check any that apply)

◯ Breathing problems ◯ Infection ◯ Rh factor
◯ Birth defects ◯ Feeding concerns ◯ Needed incubator
◯ Needed oxygen ◯ Blue spells ◯ Convulsions
◯ Jaundice ◯ Other ___________________

DEVELOPMENTAL MILESTONES:

How did child meet developmental milestones, compared to brothers, sisters, peers?

Sitting alone	◯ Faster	◯ Slower	◯ Equal
Talking	◯ Faster	◯ Slower	◯ Equal
Toilet Training	◯ Faster	◯ Slower	◯ Equal
Walking	◯ Faster	◯ Slower	◯ Equal

Has your child received: ◯ Speech ◯ Occupational therapy ◯ Physical Therapy
◯Counseling ◯ Special Education Services

Describe any developmental concerns: ____

Signature of Parent/Guardian: ____________________________________ Date: _____________