Print Form

# SOLVAY UNION FREE SCHOOL DISTRICT

## *Student Health Services*


**Solvay Elementary School**
***Grades K – 3***
**701 Woods Road**
**Solvay, NY 13209**
**Phone: 488-5422**
**Fax: 484-1417**

**Solvay Middle School**
***Grades 4 – 8***
**299 Bury Drive**
**Syracuse, NY 13209**
**Phone: 487-7061**
**Fax: 484-1444**

**Solvay High School**
***Grades 9 - 12***
**600 Gertrude Avenue**
**Solvay, NY 13209**
**Phone: 468-2551**
**Fax: 484-1404**


## *Student Medical History (Confidential)*

***To the Parent or Guardian: Please complete this form and return it to the School Nurse.***

**Student's Name: _____ Date of Birth: _____**
**Place of Birth: _____ Sex: ☐ Male ☐ Female**
**U.S. Citizen? ☐ YES ☐ NO If "no", date entered U.S.: _____ Green card? ☐ YES ☐ NO**
**Address: _____ Home phone: _____**
**_____ Cell phone: _____**
**Father's full name _____**
**Mother's full name_____ ☐MS. ☐MRS. ☐MISS**
**Child resides with: ☐ BOTH PARENTS TOGETHER ☐ BOTH PARENTS ALTERNATING ☐ MOTHER**
**☐ FATHER ☐ STEPMOTHER ☐STEPFATHER ☐GUARDIAN ☐OTHER**
**Language spoken in home: _____**
**Names and ages of siblings living in home: _____**

**Child's Physician _____Physician's phone: _____**

***Please note: Education law requires that your child's immunization records be submitted to the school at registration, reviewed by a school health official and be in compliance with New York State requirements in order to attend school. Please submit your child's records to the nurse for review at this time. If any immunizations are still required, you will be notified. School district administrators may delay entry of non-immunized or non-documented students.***

**Has your child ever previously attended Solvay Schools? ☐ NO ☐YES If yes, grades: _____**
**Birth History:**
**Weight at birth _____ ☐ FULL TERM ☐ PREMATURE (_____wks)**
**Any problems during pregnancy? _____**
**Any problems during delivery? _____**
**Sat up at _____months Crawled at _____months Walked at _____months**
**First words at _____ months Sentences at _____months Age at toilet training _____**

**Has your child had any of the following? (Please check if YES and indicate year if known):**

| | | |
|---|---|---|
| ☐ Chickenpox | ☐ Ear conditions | ☐Allergies to _____ |
| ☐ Scarlet fever | ☐ Frequent Sore Throats | ☐ Rheumatic Fever |
| ☐ Measles | ☐ Mumps | ☐ German Measles |
| ☐ Mononucleosis | ☐ Contact with TB | ☐ Whooping Cough |
| ☐ Cancer | ☐ Serious Injury | ☐ Other _____ |

****please note: written documentation from MD now required by New York State if child has had chickenpox disease***

**Has your child had any surgical operations? ☐YES ☐NO**
**(If YES, please indicate year and type of surgery below)**
_____

**Has your child had any fractures (broken bones)? ☐YES ☐NO**
**(If YES, please indicate year and type e.g. *"left wrist – 2001"*) _____**
_____

**Has your child had any head injuries? ☐YES ☐NO If so, please give dates and details. _____**
_____

**Does your child wear glasses? ☐YES ☐NO Contact lenses? ☐YES ☐NO**
**☐DISTANCE ☐READING ☐BOTH since age _____**

**Does your child wear hearing aid(s)? ☐NO ☐YES: If "Yes": ☐RIGHT ☐LEFT ☐BOTH EARS since age _____**

**Is your child allergic to bee stings? ☐YES ☐NO If YES, has your child ever had trouble breathing or needed medical help or injections after a bee sting? ☐YES ☐ NO If "yes", please describe: _____**

***(over)***

**Does your child have any other allergies? (Hay fever, food, medicine, other?)** ☐**YES** ☐**NO**
**(If YES, to what is your child allergic?)**
_____

**Has your child ever had a seizure(s)?** ☐**YES** ☐**NO**
**(If YES please indicate type and frequency of seizures, any "aura" or "warning" symptom before seizures, any seizure medication used now or in the past and name of doctor caring for this condition.)**
_____
_____

**Have you ever been told that your child has a heart murmur?** ☐**YES** ☐**NO**
**(If YES, please indicate what age, activity restrictions if any and name of doctor caring for this condition.)**
_____
_____

**Is your child taking any medication at this time?** ☐**YES** ☐**NO**
**(If YES, please indicate name of medication, dosage and reason for medication.)** _____
_____

**Does your child need medication during school hours?** ☐**YES** ☐**NO**
**(If YES, please have your physician complete the attached form. This is a New York State requirement for prescription and non-prescription medication in schools.)**

**Does your child have diabetes?** ☐**YES** ☐**NO**
**(If YES, please have your physician complete the attached form and include a complete schedule of glucose monitoring and insulin injection at school. Please provide a glucose monitor to be kept at school.)**

**Does your child require a rest period during the school day for medical reasons?** ☐**YES** ☐**NO**
**(If YES, please ask your physician to mail/fax us a statement in this regard.)**

**Does your child require frequent use of the lavatory?** ☐**YES** ☐**NO**
**(If YES, please indicate condition [confidential]. Teachers will be informed only that "for medical reasons the student should have unrestricted lavatory access.")** _____

**Does your child (grades 7 – 12) participate in Interscholastic Athletics?** ☐**YES** ☐**NO**
**(If YES, a sports physical is required once yearly by your private or our school MD. Exams are held at school in August, October, March and May.)**

**Regarding Physical Education class (grades K – 12), does your child currently participate in (check one):**
☐ **Regular Phys. Ed – no activity restrictions**
☐ **Regular Phys. Ed – currently restricted due to recent illness/injury**
**(Please have physician treating the condition send us documentation.)**
☐ **Adaptive Phys. Ed Program as ordered by private MD or Special Education Department.**

**Does your child require barrier free access and elevator due to temporary or permanent use of crutches, walker, wheelchair or other mobility aide?** ☐**YES** ☐**NO** **(If YES, type of aide used: _____)**

**Does your child require daily medical treatment or procedure during school?** ☐**YES** ☐**NO**
**(If YES, please indicate name of procedure and provide physician's written order and required treatment supplies, e.g. catheters, feeding tubes.)** _____

**At previous schools, has your child received Special Education services?** ☐**YES (IEP) (504)** ☐**NO**
**(If YES, please state type of services e.g. Resource Room, Physical Therapy, Speech Therapy, etc.)** _____
_____

**Does your child receive counseling now or in the past?** ☐**YES** ☐**NO**
**(We realize this is sensitive and confidential information. You need not elaborate, but if you would care to discuss the circumstances, please consult the nurse, guidance counselors, psychologist or social worker.)**

**Is there any other circumstance or condition of which the school should be aware for your child's health, comfort and safety?**
_____
_____
_____

**THANK YOU FOR PROVIDING THIS IMPORTANT INFORMATION FOR YOUR CHILD'S HEALTH AND SAFETY.**

**Signature** _____ **Date** _____

**Relationship to student:** _____