

To be completed by parent/guardian.

**PELHAM PUBLIC SCHOOLS  
PELHAM, NEW YORK**

**PARENT HEALTH & INFORMATION SURVEY**

Student \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
School \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Grade/Class \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Father's Occupation \_\_\_\_\_ Mother's Occupation \_\_\_\_\_  
Business/Cell Phone \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_

**Physical Exam** has/will be done by Dr. \_\_\_\_\_ on \_\_\_\_\_  
(Mandatory Grades K, 2, 4, 7,10)

Is there anything concerning your child's health that the school should know to provide necessary care?

If yes, please explain \_\_\_\_\_

Does your child wear glasses? \_\_\_\_\_ Date of last examination \_\_\_\_\_ by Dr. \_\_\_\_\_

Has your child had any illness or operations since the last school year?

If yes, please explain \_\_\_\_\_

Does your child take any medication? \_\_\_\_\_ Name/Dosage of Medication \_\_\_\_\_

**Allergies to medication** (type) \_\_\_\_\_ **Allergies to food** (type) \_\_\_\_\_

**Allergies to environment/other** \_\_\_\_\_

**EMERGENCY INFORMATION**

**Local** people/babysitter to be called in the case of an emergency or illness when a parent/guardian is not available:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

**Doctor** to be called if necessary:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Dentist** to be called if necessary:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Preexisting Dental Conditions \_\_\_\_\_

**(OVER)**

Has the child had any of the following? Please check and give approximate dates.

Chicken Pox \_\_\_\_\_

Asthma \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Hay Fever \_\_\_\_\_

Tuberculosis in Family \_\_\_\_\_

Hives \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Condition \_\_\_\_\_

Scoliosis \_\_\_\_\_

Seizure Disorder \_\_\_\_\_

Hepatitis \_\_\_\_\_

Ear Infection \_\_\_\_\_

Blood Disorders \_\_\_\_\_

Operations/Accidents \_\_\_\_\_

Any other existing conditions or significant past medical history

\_\_\_\_\_  
\_\_\_\_\_

### **DISTRICT MEDICATION POLICY**

When a child needs to take medication at school, ALL medication MUST:

1. Be prescribed by a licensed prescriber
2. Be labeled with the child's and physician's name by the pharmacy
3. Have directions for dispensing on the bottle
4. Be accompanied by permission note from parent or guardian

Transfer of student health records: I hereby authorize the release of a copy of the student health records of my child in the event of his/her transfer to another school district.

\_\_\_\_\_  
Signature of Parent/Guardian