UNIONDALE PUBLIC SCHOOLS
UNION FREE SCHOOL DISTRICT
933 Goodrich Street
Uniondale, New York 11553-2499

CAL AVE.	GRAND AVE.	NORTHERN
SMITH ST.	WALNUT ST.	U.H.S.
L. RD.M.S.	TURTLE. H.M.S.	U.H.S. / ALT
Pre-K Eval	Evaluation	

Student ID # ____________________

Health Office Log # ________________

HEALTH HISTORY FORM

CHILD'S NAME____
Last First Initial Sex Date of Birth Place of Birth

ADDRESS____
Street Town Home Phone /Cell Phone #

PARENT/GUARDIAN ____
Mother's Name Phone # (Cell/Work) Father's Name Phone # (Cell/ Work)

NAME OF PREVIOUS SCHOOL____-____________________

LAST TIME @ UNIONDALE SCHOOL ____________________________**DISCHARGE DATE**_________________________

EMERGENCY CARE (NAME/ PHONE # OF (2) TWO RELATIVES OR FRIENDS TO CALL IN CASE OF EMERGENCY:

1. ____
Name Phone # (C/ W/H) circle one Relationship to student
2. ____
Name Phone # (C/ W/H) circle one Relationship to student

____
Healthcare Provider (Doctor) **Address** **Phone #**

****** NURSE WILL DO A VERBAL INTERVIEW ******

ANSWER YES OR NO (GIVE SPECIFIC DETAILS TO YES ANSWERS) ALL QUESTIONS IS IN REFERENCE TO YOUR CHILD

Surgery/Operations___________________________________
A Serious Illness or Disease ___________________________
A Serious Accident ___________________________________
A Head Injury of Unconsciousness _____________________
A Hospital Stay ______________________________________
If yes, Name of Hospital _______________________________
Reason for Hospitalization______________________________
A Vision Problem _____________________________________
Eye Glasses/ Contacts__________________________________
A Hearing Problem ____________________________________
Hearing Aids ____

Any Other Illnesses ___________________________________
Specify ____

A Birth Defect ____
A Chronic Illness _____________________________________
Allergies ____
Specify____
Asthma ____
Medications ____
Specify Home or School _________________________________
Lung Disease ____
Diabetes ____
Kidney Disease ____
Heart Disease/ Murmur ___________________________________
Family History of Heart Disease ____________________________
Seizures/Convulsions _____________________________________

Any Physical Limitations_________________________________
Specify ____

Can Child Participate In All Activities Including Gym/ Swimming ____

These statements are true to the best of my knowledge. I give permission for the school health personnel to contact the Health provider (Doctor) named above for any needed health information.

____
Signature of Parent / Guardian **Date**