# PNWlogo_lrg.jpgPutnam/Northern Westchester

# BOARD OF COOPERATIVE EDUCATIONAL SERVICES

200 BOCES Drive, Yorktown Heights, NY 10598-4399

(914) 248-2270 FAX (914) 245-2427

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**Student Health History/Emergency Contact Update**

 The Student Health History/Emergency Contact form is the school’s annual updating of information on your child.

 It is the most effective way to get to know your child, his/her medical history and any changes in your child’s physical

 condition. It brings the school nurse up-to-date so that, if an emergency occurs, your instructions may be followed and

 the proper people (including your doctor) may be contacted. Please take the few minutes necessary to complete this

 important form (both front and back) and return it to the school nurse at your child’s school.

 Please call the school nurse if you have any questions or if your child has a change in medication during the school year.

 Walden Health Office Pines Bridge Health Office Fox Meadow Health Office

 914-248-2282 914-248-2254 914-248-3660

|  |  |  |
| --- | --- | --- |
| Name:  | DOB: Age: | Gender: 🞎 M 🞎 F |

|  |  |  |  |
| --- | --- | --- | --- |
| **Has your child ever:** | **YES** | **NO** | **If Yes, please explain and include date:** |
|  Had an ongoing medical condition |  |  |  |
|  Seen a medical specialist |  |  |  |
|  Had allergies: to food, medication, environmental,  insect sting, other |  |  |   |
|  Been hospitalized |  |  |  |
|  Had an operation |  |  |  |
|  Had an injury requiring an Emergency Room visit |  |  |  |
|  Missed 5 days of school in a row due to illness/injury |  |  |  |
|  Had a bone/muscle injury |  |  |  |
|  Passed out, had a concussion or serious head injury |  |  |  |
|  Had a convulsion/seizure |  |  |  |
|  Had a vision problem or condition |  |  |  🞎 glasses 🞎 contacts |
|  Had a hearing problem or condition |  |  |  🞎 hearing aid 🞎 cochlear implant |
|  Worn dental bridge, braces or mouthpiece |  |  |  |
|  Have an implanted medical device? |  |  |  |

 **CHECK ALL THAT APPLY TO YOUR CHILD:**

🞎 ADHD

🞎 Asthma/trouble breathing

🞎 Autism/Asperger

🞎 Dental Injuries

🞎 Diabetes

🞎 Ear Infections

 🞎 GI Conditions (ulcer, reflux, IBS)

🞎 Headaches/migraines

🞎 Heart Conditions

🞎 High Blood Pressure

🞎 Mental Health Condition

 (depression, anxiety, OCD, ODD, etc.)

🞎 Scoliosis

🞎 Single Organ (🞎kidney, 🞎testicle)

🞎 Skin Condition

🞎 Speech Condition

🞎 Urinary Condition

|  |  |  |  |
| --- | --- | --- | --- |
| **CURRENT MEDICATIONS** | **YES** | **NO** | **Please list name, dose, time(s)****(use separate sheet if necessary)** |
| Given at school |  |  |  |
| Taken at home |  |  |  |
| **ASSISTIVE EQUIPMENT** | **YES** | **NO** | **Please check all that apply** |
| During or outside of school |  |  | 🞎crutches 🞎walker 🞎wheelchair 🞎other:  |
| **TREATMENTS** | **YES** | **NO** |  |
| During or outside of school |  |  | 🞎insulin/blood glucose monitoring 🞎inhaler/nebulizer/peak flow monitoring 🞎special diet  |

Is there any condition that would prevent your child from participating in physical education or sports?

🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Family Physician’s Name: |
| Physician’s address: |
| Physician’s telephone #: |

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Name of someone who can be called in case of an emergency when you cannot be reached. Please be sure to list the name of persons who will be able to respond in an emergency |
| #1. | #2. |
| Name: | Name: |
| Relationship: | Relationship: |
| Home telephone #: | Home Telephone #: |
| Cell Phone #: | Cell Phone #: |