



# VALLEY STREAM

## UNION FREE SCHOOL DISTRICT THIRTEEN

### HEALTH RECORD

(This form must be filled out in its entirety)

**SCHOOL:** James A. Dever \_\_\_\_\_ Howell Road \_\_\_\_\_ Wheeler Avenue \_\_\_\_\_ Willow Road \_\_\_\_\_

**HISTORY:** Date: \_\_\_\_\_

Pupil Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ Doctor's Phone Number: \_\_\_\_\_

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Has your child had any of the following diseases?

	Date		Date
Asthma/ Allergies	_____	Mumps	_____
Diabetes	_____	Pneumonia	_____
Chicken Pox	_____	Rheumatic Fever	_____
Ear Condition	_____	Scarlet Fever	_____
Frequent Colds/ Sore Throat	_____	Seizure Disorder	_____
German Measles	_____	Tuberculosis	_____
Heart Disease	_____	Vision Problems	_____
Measles	_____	Whooping Cough	_____

Operations: \_\_\_\_\_ Types of Operations: \_\_\_\_\_ Date: \_\_\_\_\_

Serious Injuries: \_\_\_\_\_ Types of Injuries: \_\_\_\_\_ Date: \_\_\_\_\_

Was there an unusual pregnancy and/or delivery with this child? Explain \_\_\_\_\_

Are there any medications your child is currently taking at home?

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time(s) Given: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time(s) Given: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time(s) Given: \_\_\_\_\_

Is there any other information that you feel will help us to understand and care for your child?

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