

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH DATA SHEET FOR NEW STUDENTS

NAME OF STUDENT: _____ GRADE: _____

Please note →

A copy of your child's birth certificate and immunizations are required at time of registration.

| | | | |
|------------------|-------|----------------|-------|
| Family Physician | | Family Dentist | |
| _____ | _____ | _____ | _____ |
| Name | Phone | Name | Phone |

HISTORY: Please check diseases or illnesses your child has had.

- Tuberculosis
- Heart Disease
- Sore throats, freq. colds
- Convulsions/seizures
- Orthopedic defects
- Period of unconsciousness/fainting spells
- Speech
- Lungs
- Asthma
- Bronchitis/Pneumonia
- Migraine headaches
- Nervous system
- Head Injury/Concussion
- Kidney/urinary problem
- Hernia, actual or potential
- Freq. Ear infection
- Growths, tumors
- Gastrointestinal disorder
- Alcoholism/Drug addiction
- Fractures or Dislocations
- Joint pain/injury
- Sinus
- Diabetes
- Epilepsy
- If yes to any of the above, please describe: _____

- Allergic to: (medication, food and/or insect bites) _____
- Reaction to Allergy and recommended treatment: _____

- Is there anything concerning vision, hearing, or general health of your child that the school should know about in order to provide special care? _____

Is your child currently taking medication(s) prescribed by a physician and/or any over the counter medications? YES NO

Medications(s) and Dosage(s) _____
Name of doctor who prescribed medication(s) _____
Condition medication is prescribed for _____

Please refer any questions or concerns to Bev Martin, RN; Head of Health Services—287-1902

Parent/Guardian Signature

Date