

Gowanda Central School District
Student Health Information

STUDENT NAME: _____ **BIRTH DATE:** _____

CHILD'S DOCTOR: _____ **Phone:** _____

STUDENT'S HEALTH INSURANCE: _____
DOES NOT HAVE HEALTH INSURANCE ☐

CHILDHOOD ILLNESSES: Has your child had any of the following diseases? Please check all that apply.

Chicken Pox	_____	Pneumonia	_____
3-Day Measles (German)	_____	Rheumatic Fever	_____
9-Day Measles	_____	Polio	_____
Mumps	_____	Diphtheria	_____
Whooping Cough	_____	Scarlet Fever	_____

Explanation of above, if needed: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? Please explain:

Asthma _____

Frequent Colds _____

Heart Disease _____

Diabetes _____

Epilepsy _____

Hemophilia _____

Tuberculosis _____

Ear Conditions _____

Other _____

ALLERGIES: (Please list the agent to which your child is allergic and any treatment needed and severity of allergy.)

HAS YOUR CHILD HAD ANY OF THE OF THE FOLLOWING: (Please explain fully.)

Operations : _____

Serious Injuries: _____

Unusual Illnesses: _____

IS YOUR CHILD ON MEDICATION? YES ☐ NO ☐ **NAME & DOSAGE:** _____

(If Medication is needed in school You must have a Dr. order and parent permission on file with the Nurse)

****TURN OVER PLEASE****

IS THERE ANYTHING SPECIAL ABOUT YOUR CHILD THAT WE SHOULD KNOW? _____

Speech Problems _____
Hearing Problems _____
Vision Problems _____
Hyperactivity _____

Emotional Problems _____
Temper Tantrums _____
Aggressiveness _____
Shyness _____

Any Fears? _____

Is there any language spoken at home besides English? _____

PHYSICALS: Students in special education classes, kindergarten, 2nd, 4th, 7th & 10th grades and all new students, regardless of grade level, will have a physical in school unless you prefer to have it done by your private physician. If you have a private physical –a copy must be provided to the building Nurse or a school physical will be done. **A Dental Certificate and BMI Weight Status Category** are also required of students in these grades.

Please indicate your preference:

____ School Physical

____ Private Physician Physical

I, _____, have read the foregoing and have fully, truthfully and accurately answered the questions.

Signature of Parent/Guardian

Date

Print Parent/Guardian Name: _____

IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY:

We must have a copy of your Child's immunization record on or before the first day of school attendance in order for your child to attend school. THIS MUST BE **FROM A DOCTOR AND SIGNED BY THE DOCTOR** to be valid. We cannot accept a former school Health Record for immunizations.