

Return Promptly

Student Full Name _____

Date _____

Date of Birth _____ Birthplace _____ Gender: M F Grade _____

Student Cell Tel (if he/she has one) _____ Home Language _____

Date entered USA, if born in foreign country _____

Ethnicity (choose one) White Black Hispanic American Indian/Alaskan Native Asian/Pacific Islander

Home Address _____ Apt. # _____

Home Tel _____ Cell Tel _____

Mailing address_(if different) _____

Previous School District Attended _____

Previous School Address _____

Has child ever attended Port Jervis Schools? Yes or No If Yes, When? _____

Name of Brothers and Sisters (Last, First, Middle)	School they attend
_____	_____
_____	_____
_____	_____

Child lives with: Both Parents Mother Father Guardian Step-Parent Other _____

Parent / Guardian Name _____

Address (if different) _____

Relationship to student _____ Date of birth _____

Employer's Name _____

Work Tel _____ Cell Tel _____ Email _____

Parent / Guardian Name _____

Address (if different) _____

Relationship to student _____ Date of birth _____

Employer's Name _____

Work Tel _____ Cell Tel _____ Email _____

If parent / guardian cannot be reached:

Emergency Contact _____ Relation to Child _____

Address _____

Work Tel _____ Cell Tel _____ Email _____

Are there any **CUSTODY** issues we should be aware of? *Be specific* _____

Does your child have – OR - has your child ever had any of the following (check all that apply):

- Eating issues weight issues head injury / concussion eye injury vision problems glasses / contacts
- seizures hearing problems speech problems

Does your child have FREQUENT:

- colds sore throats sinus infections tonsillitis headaches migraines ear infections
- bronchitis eczema rashes other: _____

Does your child have a history of – OR - currently being treated for any of the following:

(Please indicate dates, current treatment or medication)

ADHD _____ Scoliosis _____ Diabetes _____

Thyroid problems _____ Toileting problems _____ Kidney/Urinary problems _____

Heart murmur _____ Heart Disease _____ Blood Disorder _____

Broken bones/fractures _____ Operations _____

Hospitalizations _____ Other: _____

When was the last time your child went to the dentist: _____

ASTHMA: Does your child have asthma that has been diagnosed by a doctor? Yes No

If YES, what type: chronic bronchial exercise other: _____

ASTHMA MEDICATION:** What type of asthma treatment ** does your child use? * Be Specific *

INHALER NEBULIZER PILL: _____ OTHER _____

ALLERGIES: Does your child have ANY allergies? Yes No known allergies

Which allergies have been diagnosed / confirmed by a doctor? _____

Please list ALL allergies and your child's REACTION (Be specific)

FOODS _____ LACTOSE INTOL _____ BEES _____ INSECTS _____

ANIMALS _____ ENVIRONMENTAL/SEASONAL _____

DRUGS/ANTIBIOTICS _____ OTHER _____

What medication** / treatment does your child take for allergies? _____

Do you have any OTHER HEALTH CONCERNS about your child? _____

In order for a child to receive ANY medication in school, over the counter or prescription, the following is required:

1. MEDICATION FORM COMPLETED BY DOCTOR AND SIGNED BY PARENT
2. MEDICATION MUST BE IN ORIGINAL CONTAINER
3. CONTAINERS MUST HAVE STUDENT'S NAME ON IT
4. MEDICATION MUST BE BROUGHT TO SCHOOL BY AN ADULT. STUDENTS ARE NOT PERMITTED TO CARRY MEDICATION.

NEW YORK STATE MANDATED PHYSICALS AND SCHOOL HEALTH SCREENINGS:

PHYSICALS are required as follows: All new entrants; Kindergarten, Gr1; Gr 3, Gr 5, Gr 7; Gr. 9, Gr 11, Participation in sports; Working papers
The district supplies the examinations, at no charge, for students who have their physicals done in school.

I request the School Doctor/Nurse Practitioner do the Physical.

My child's physical will be done by our private physician: _____

* Proof of physical or appointment date must be provided. If no response is received within 30 days, the student will have a physical with the school doctor/nurse practitioner.

SCREENINGS are done by school personnel as follows: *Scoliosis: Girls – Gr 5 & 7 Boys – Gr 9

*Vision/Hearing: Grades Kg, 1, 3, 5, 7, 11 and All New Entrants

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I understand confidential and discreet use of the above information as well as any health evaluation by the school nurse practitioner will be shared as needed to meet my child's health and educational needs.

Parent / Guardian Signature

Date