Enlarged City School District of Middletown—Health Services
New Entrant Health History

Name of scholar_____School entering_____Grade_____
Date of Birth_____Place of birth_____Gender (male/female) _____
Address_____Home phone_____
Mother (name & birthplace) _____
Father (name & birthplace) _____
Scholar's dominant language _____Second language_____
Last school attended (name, address & phone #) _____
Prenatal & birth history (please describe any unusual events or special treatment required during pregnancy, labor, delivery or hospital stay) _____

Early development history (please include any information about physical growth concerns, health problems or developmental delays) _____

Medical history Date of last physical exam_____Results_____
Health Care Provider's name and phone #_____

Does your scholar take prescription or non-prescription medication?_____If yes, please indicate name of medication, dosage and time taken_____
If medication needs to be administered while at school, please complete the appropriate medication forms available at Central Registration or from your school nurse.

Any allergies to: Food_____Insect Stings___Pollens___Dust___Grass___Animals___Other_____
Please complete the allergy questionnaire available at Central Registration or from your School Nurse.

Any history of speech or language problems? _____Hearing problems? _____Vision problems? _____
Has your scholar ever received services from: Physical therapist?___Occupational therapist?___Speech pathologist?____
Psychological counseling?____If yes, please explain_____

ILLNESSES/INJURIES	If yes, please indicate date/treatment given	ILLNESSES/INJURIES	If yes, please indicate date/treatment given
Attention Deficit Disorder		Lead testing	
Asthma		Muscle or joint injury	
Bladder/Bowel		Pneumonia	
Blood pressure		Scarlet fever	
Chicken pox		Scoliosis	
Concussion		Seizure disorder	
Diabetes		Sickle cell trait/disease	
Ear infections (frequent)		Skin disorders	
Fainting/dizziness		Surgical operations	
Fractures/broken bones		Toileting problems	
Heart problems/murmur		Tonsillitis	
Juvenile Rheum. Arthritis		Tuberculosis/skin test	

Additional medical history_____
All health information will be handled in a respectful and confidential manner. The school health personnel will share this information with other school staff on a "need to know" basis only.

Parent/Guardian signature_____Date_____