Hoosic Valley Central School District

NEW ENTRANT HEALTH HISTORY

DATE:_____

Student's Name:_____ Gender: □ Female □ Male

DOB:_____ Grade_____ Previous School:_____

Home Phone:_____ Home Address:_____

Student's Physician:_____Phone:_____

Date of last physical:_____(****Please note-the school requires a copy of the current physical exam to be provided upon entry.)**

Eye Problems: Y N Wears Glasses: Y N

Opthamologist/Optometrist:_____

Ear Problems Y N Tubes in Ears: Y N

ENT Physician:_____

_____

Has History of: (check all that apply/explain below)

Allergies □ Food □ Bees □ Medication □
Anemia □
Asthma □
Bronchitis □
Chickenpox □
Diabetes □
Heart Disease/Problems □
Bleeding Disorders □
High Blood Pressure □
Mononucleosis □
Concussion □
Pneumonia □
Scarlet Fever □
Rheumatic Fever□
Epilepsy/Seizures □
Surgery □
Kidney Problems □
Sickle Cell Anemia□
Hepatitis □
Meningitis □
Orthopedic/Fractures □
Other □

Please explain any of the areas checked above in detail:

_____

_____

_____

_____

Currently taking any medication(s): Yes □ No □

If yes, what medication(s)_____

Parent/Guardian Signature:_____Date:_____