St. Thomas School

St. Thomas the Apostle School Health Office
42 Adams Place · Delmar, NY 12054
(518)439-5573 Phone · 518-478-9773 fax

FORM B

Health History for New Entrants

Name: _____ Date of Birth __/__/____ Grade _____

Address: _____ Phone: _____

Mother/Guardian Name: _____ Father/Guardian Name: _____

Student's Physician: _____ Phone: _____

Last Visit to M.D. __/__/____ Reason: _____

Date of Last Physical __/__/____ Next Visit to M.D. __/__/____ Reason: _____

Health History

Serious Illness: _____

Serious Injury: _____

Surgery: _____

Place a check in the appropriate box if your child has or has had any of the following. Provide date if applicable.

- ☐ Allergies
  - ☐ Bee Sting
  - ☐ Food
  - ☐ Medication
  - ☐ Other
- ☐ Anemia
- ☐ Asthma
- ☐ Cerebral Palsy
- ☐ Chicken Pox (documentation)
- ☐ Colds & Sore Throats
- ☐ Seizures
  - ☐ With Fever
  - ☐ Without Fever
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Ear Infections
  - ☐ History of PE Tubes
- ☐ Eye Conditions
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Hypotonia
- ☐ Kidney Disease
- ☐ Learning Disabilities
- ☐ Leukemia
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Orthopedic Conditions
- ☐ Pneumonia
- ☐ Rheumatic Disease
- ☐ Rubella Disease
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Speech Problem
- ☐ Strep Throat
- ☐ TB
  - ☐ Chest X-ray
- ☐ Urinary Infections
- ☐ Vision Problem
- ☐ Whooping Cough

Last Vision Exam: __/__/____ Vision Specialist: _____

Glasses Worn: ☐ Yes ☐ No

Current Health Status: (Please state if your child is, or has been, under treatment, or taking medication)

Health Conditions under treatment: _____

Medical Provider(s) providing treatment: _____

Medications Prescribed: _____

Will Medications need to be given while your child is at school? ☐ Yes * ☐ No ☐ Unknown at this time

*MD order and proper documentation required.

Are there any physical restrictions or limitations for physical education or other activities at school? ☐ Yes * ☐ No

*If physical restrictions or limitations, M.D. documentation is required.

Has your child ever received, or is your child currently receiving one of the following services:

☐ OT ☐ PT ☐ Speech ☐ Other

Parent/Guardian Signature: **Date:**