Highland Falls-Fort Montgomery CSD
HEALTH HISTORY FORM

Grade _____ Date _____

Name _____ Sex _____ Date of Birth _____

Address _____

_____

P. O. Box _____ Apt. #_____ Phone. _____

Father's Name _____Business No.: _____

Mother's Name _____ Business No.: _____

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If your child has had any of the following, please check the box:

- ❑ Frequent Colds
- ❑ Epilepsy
- ❑ Diphtheria
- ❑ Pneumonia
- ❑ Heart Disease
- ❑ Contact w/T. B.
- ❑ T. B.
- ❑ Developmental Delays
- ❑ Other

- ❑ Frequent Sore throat
- ❑ Frequent Earaches
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ Whooping Cough
- ❑ Speech/Language problems
- ❑ Serious injury
- ❑ Tonsils/Adenoids removed

- ❑ Diabetes
- ❑ Defective eyesight
- ❑ Defective hearing
- ❑ .Hospitalization
- ❑ Surgery
- ❑ Asthma
- ❑ Allergy
- ❑ Headaches

_____

PLEASE EXPLAIN if you check a box above:

_____
_____
_____
_____
_____

1. Has your child had any other screening or evaluations (Neurological, psychological, psychiatric, etc.)? Yes _____ No _____ Date: _____

If so, for what were the results

_____

2. Is your child currently on any medications? _____ Yes _____ No

If so, please list

_____

_____

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Please note:
New York State Department of Health is now requiring a Dental Health Certificate.
Please make every effort to have your child seen by a dentist.

3. Has your child ever seen a dentist? _____ Yes _____ No
If so, for what was the result of the examination and recommendations?
_____

(For PreK and K children)

4. Is there any pertinent information we need to know that occurred during pregnancy and/or childbirth?
_____
_____
_____

5. At what age did your child
a) Speak in sentences _____ b) learn to walk _____ c) toilet trained _____

6. Is there anything concerning your child's physical or mental health which the school should know in order to provide special care?

_____
_____
_____
_____

Physician: _____ Phone No.: _____

Dentist: _____ Phone No.: _____

2/2009