Niskayuna Central School District

Health History Form

Student Information

Name: _____ Grade: _____

Home Address: _____

Date of Birth: _____ Place of Birth: _____ Sex: _____

Parent(s)/Guardian)s): _____ Phone: _____

Father's Occupation/Business Address: _____

_____ Phone: _____

Mother's Occupation/Business Address: _____

_____ Phone: _____

Family Physician/Pediatrician: _____ Phone: _____

Dentist: _____ Phone: _____

Check if your child had had any of the following:

- ☐ Chicken pox
- ☐ Diphtheria
- ☐ German Measles
- ☐ Mumps
- ☐ Measles
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ Pneumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Contact with TB

Check if your child has a history of any of the following and describe on reverse side:

- ☐ Asthma or allergies
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Eye Condition
- ☐ Ear Condition
- ☐ Frequent colds/sore throats
- ☐ Diabetes

Please indicate if there is a history of any hospitalizations, significant injuries or surgery and describe:

_____

_____

Please indicate if your child is under treatment at this time for any other condition:

_____

Growth and Development

Birth weight: _____ Delivery (normal or premature): _____

Walked at age: _____ Talked at age: _____

Parent/Guardian Signature: _____ Date: _____