

**MOUNT SINAI SCHOOL DISTRICT
MOUNT SINAI, NEW YORK**

HEALTH HISTORY

Name of Child _____ Grade _____ Teacher _____

Sex _____ Date of Birth _____ Place of Birth _____

Home Address _____ Phone _____

Parent/Guardian _____

Place of Employment _____ Phone _____

Parent/Guardian _____

Place of Employment _____ Phone _____

Physician to be notified in emergency _____ Phone _____

Two local relatives/friends to notify in case of emergency:

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Does your child wear glasses? _____ Doctor _____ Date of last exam _____

Does your child have a hearing problem? _____ Doctor & number _____

Child's Dentist _____ Date of last exam _____

Does your child have any allergies? _____ Type of allergy? _____

Does your child have asthma? _____

Does your child take medication regularly? _____ If so, what medication and why? _____

Serious injuries (type/year) _____

Operations (type/year) _____

Is there anything else concerning your child which the school should know (Speech, IEP, 504, Health Concern) in order to provide special care? _____

Parent/Guardian Signature _____ Date _____