Waterford-Halfmoon Union Free School District **125 Middletown Road, Waterford, NY 12188**
Telephone: (518)237-0800
District Office Extension: 3309
Jr./Sr. High School Office Extension: 3701
Jr./Sr. High School Guidance Extension: 3314
Elementary Office Extension: 3501
Central Registration Office Extension: 3710

STUDENT HEALTH HISTORY

Student's Name _____ Phone _____
Address _____
Birth Date _____ Sex _____ Birthplace_____
Father's Name _____ Mother's Name _____

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HEALTH HISTORY

***** If your child has a vision, hearing, or any other problem which might affect his school work, please give a brief description on the back of this form.**

Please indicate if your child has had any of the following conditions by giving dates:

Allergies_____ Asthma _____ Chickenpox_____ Diabetes_____ Dental Problems_____ Epilepsy _____

Heart Disease _____ Nose Bleeds _____ Operations _____ Serious Injuries _____ Other _____

Proof of required immunizations and completed physical is requested at registration for Grades K-12. If the information is not available at the time of registration, a student may enter school; however immunization information and proof of physical **must be submitted within 14 days** to the school. Incoming kindergarten students must be fully immunized prior to starting school.

Daily Medications

All medications prescribed and over-the-counter require a physician's written order. Additional medication can be listed on the back of this form.

Name:_____ Dosage/Time:_____

Name:_____ Dosage/Time:_____

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NYS Laws require all students in grades **K, 2, 4, 7 and 10; new students entering the district and all student athletes** receive a health examination during the school year.

☐ I Do Give ☐ I Do Not Give permission for the mandated physical to be conducted by the school physician. K-12 physicals must be completed on or after June 1st for the following school year.

☐ The School Nurse has my permission to share any health related information with other staff members who work with my child.

☐ I authorize my childs's healthcare provider listed below to release the medical records of my child to the School Nurse.

Healthcare Provider:_____ Phone: _____ Fax:_____

☐ May Participate in all Physical Education activities: Yes____ No____ If no, state reason why:_____
If a child is unable to participate in Physical Education activities a doctor's note will be required.

Parent Signature: _____ Date: _____

Please provide any additional information or comments you would like to share regarding your child's health on the back of this form.