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 _____

Father's Name _____

Place of Employment _____Phone _____

Mother's Name _____

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? _____What is the allergy? _____

_____

Does your child have asthma? _____

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

_____

Is there anything concerning the eyes, ears or general health of your child which the school should know in order to provide special care?_____

_____

_____

Operations (type/year)_____

Serious injuries (type/year)_____

Parent/Guardian Signature _____ Date _____