

**SYRACUSE CITY SCHOOL DISTRICT  
HEALTH SERVICES INFORMATION SHEET**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex M/F \_\_\_\_\_

School \_\_\_\_\_ Date \_\_\_\_\_ Grade \_\_\_\_\_

Address (incl. Zip) \_\_\_\_\_ Phone# \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Doctor \_\_\_\_\_

Has this child ever attended a Syracuse City School? Yes \_\_\_ No \_\_\_ Last school attended \_\_\_\_\_

Insurance \_\_\_\_\_ Medicaid # \_\_\_\_\_

**HEALTH SURVEY**

**PLEASE GIVE DATES AND A BRIEF DESCRIPTION OF THE FOLLOWING REGARDING YOUR CHILD:**

Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Serious Illnesses \_\_\_\_\_

Accidents \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Surgeries/Hospitalizations/ER Visits \_\_\_\_\_ Date: \_\_\_\_\_

Are any of the following relevant to your child? Please explain in the space allowed at the end.

- Check if any problems with :**
- |   |  |
|---|--|
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Emotional Problems    |
| <input type="checkbox"/> Ear Problems         | <input type="checkbox"/> Blood Disorder        |
| <input type="checkbox"/> Eye Problems/glasses | <input type="checkbox"/> Hepatitis A or B      |
| <input type="checkbox"/> Asthma Diagnosis     | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Skin rashes           |
| <input type="checkbox"/> TB                   | <input type="checkbox"/> Increased Lead levels |
| <input type="checkbox"/> Other                |  |

Activity level/restrictions \_\_\_\_\_

***IN THE FOLLOWING SPACE EXPLAIN ANY OF THE ABOVE OR ADD ADDITIONAL INFORMATION THAT WILL HELP US TO HELP YOUR CHILD.***

\_\_\_\_\_  
\_\_\_\_\_

Are there any major health problems of any other family members? Explain \_\_\_\_\_

\_\_\_\_\_

Special equipment/supplies needed \_\_\_\_\_

**Pregnancy and Delivery:** Birth weight \_\_\_\_\_ Length of pregnancy \_\_\_\_\_ Labor \_\_\_\_\_

Type of delivery \_\_\_\_\_ Complications? \_\_\_\_\_

**Growth and Development** (Please fill in age at which task was accomplished)

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_ Toilet Trained \_\_\_\_\_

**COPY AND ATTACH IMMUNIZATION RECORD TO BACK OF FORM**