

EAST RAMAPO CENTRAL SCHOOL DISTRICT

OFFICE OF SPECIAL STUDENT SERVICES
105 South Madison Avenue, Spring Valley, NY 10977
Phone: (845) 577-6040
Fax: (845) 577-6059

New Entrants Health History **Health/Safety Clearance to Participate in Physical Education** Based on Sections 903 and 3204 of the Education Laws

Pending the receipt of a completed medical history and physical examination form from your health care provider, we are asking that you provide the following information.

Students Last Name/First Name	Date of Birth	Grade/Class	
1.	Does your child have a history of the following?	If yes, please explain:	
	ALLERGIES Yes_____ No_____	_____	
	SEIZURES Yes_____ No_____	_____	
	VISION PROBLEM Yes_____ No_____	_____	
	HEARING PROBLEM Yes_____ No_____	_____	
	MOTOR DEFICIT Yes_____ No_____	_____	
2.	Has your child had any of the following?	If yes, please explain:	
	SERIOUS ILLNESS Yes_____ No_____	_____	
	SERIOUS INJURY Yes_____ No_____	_____	
	SURGERY Yes_____ No_____	_____	
	BONE FRACTURE Yes_____ No_____	_____	
3.	Please check if your child has a history of any of the following:		
	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CHICKENPOX	<input type="checkbox"/> RHEUMATIC FEVER
	<input type="checkbox"/> DIABETES	<input type="checkbox"/> WHOOPING COUGH	<input type="checkbox"/> TUBERCULOSIS
	<input type="checkbox"/> HEART ANOMALY	<input type="checkbox"/> OVERWEIGHT	<input type="checkbox"/> POSITIVE PPD
	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> HEPATITIS A	<input type="checkbox"/> SCOLIOSIS
	<input type="checkbox"/> FREQUENT EAR INFECTIONS		<input type="checkbox"/> HYPERLIPIDEMIA
	Please explain: _____		

4.	Is your child presently or was your child under medical treatment during the past year? Yes___ No___ If yes please explain_____		

5.	Last Physical Exam Date:_____ Physician's Name_____		
6.	Is your child taking medication on a regular basis? List the medication, dosage and frequency.		

7.	Is there any other medical information we should know about your child?_____		

PRINT Name of Person Completing Form Relationship to Child Signature Date

