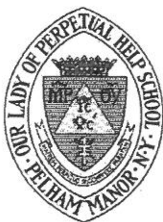

OUR LADY OF PERPETUAL HELP SCHOOL

575 Fowler Avenue Pelham Manor, New York 10803

(914) 738-5158 FAX (914) 738-8974 E-mail W502@adnyeducation.org

PARENT HEALTH & INFORMATION SURVEY

This survey is required each year and is to be completed by a parent or guardian

Student ______________________________ Date ______________________________

Address ______________________________ Home Phone ______________________________

School Our Lady of Perpetual Help Date of Birth ______________________________

Grade/Class ______________________________ Place of Birth ______________________________

Father's Name ______________________________ Mother's Name ______________________________

Place of Birth ______________________________ Place of Birth ______________________________

Father's Occupation ______________________________ Mother's Occupation ______________________________

Business/ Cell Phone ______________________________ Business/ Cell Phone ______________________________

Physical exam has/will be done by Dr. ______________________________ on ______________________________
(Mandatory grades K, 2, 4, 7)

Is there anything concerning your child's health that the school should know to provide necessary care? ______________

If yes, please explain ______________________________

Does your child wear glasses? ____________ Date of last exam ____________ by Dr. ____________

Has your child had any illnesses or operations since the last school year? ____________

If yes, please explain ______________________________

Does your child take any medication? ____________ Name/Dose of Medication ____________

Allergies to medication (type) ____________ Allergies to food (type) ____________

Allergies to environment/other ______________________________

EMERGENCY INFORMATION

Local people to be called in the case of an emergency or illness when a parent/guardian is not available:

Name ____________ Address ____________ Ph/Cell ____________

Name ____________ Address ____________ Ph/Cell ____________

Doctor to be called if necessary:

Name ____________ Address ____________ Phone ____________

Dentist to be called of necessary:

Name ____________ Address ____________ Phone ____________

Preexisting Dental Conditions ______________________________ (OVER)

Has the child had any of the following? Please check and give approximate dates.

Chicken Pox ____________________

Tuberculosis ____________________

Tuberculosis in Family ____________________

Diabetes ____________________

Scoliosis ____________________

Hepatitis ____________________

Blood Disorders ____________________

Asthma ____________________

Hay Fever ____________________

Hives ____________________

Heart Condition ____________________

Seizure Disorder ____________________

Ear Infection ____________________

Operations/Accidents ____

Any other existing conditions or significant past medical history

____

____

DISTRICT MEDICATION POLICY

When a child needs to take medication at school, ALL medication MUST:

1. Be prescribed by a licensed prescriber
2. Be labeled with the child's and physician's name by the pharmacy
3. Have directions for dispensing on the bottle
4. Be accompanied by permission note from parent or guardian

Transfer of student health records: I hereby authorize the release of a copy of the student health records of my child in the event of his/her transfer to another school district.

____

Signature of Parent/Guardian