

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:

_ ASTHMA _ CHICKENPOX _ RHEUMATIC FEVER
_ DIABETES _ WHOOPING COUGH _ TUBERCULOSIS
_ HEART ANOMALY _ OVERWEIGHT _ POSITIVE PPD
_ HYPERTENSION _ HEPATITIS A _ SCOLIOSIS
_ FREQUENT EAR INFECTIONS _ 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