Charter School for Applied Technologies

www.csat-k12.org

STUDENT HEALTH HISTORY

(This form is to be completed by the student's parent or guardian)

Student Name: Date:

Gender: Age: Birthdate:

Name of Physician: Physician Phone:

☐ YES ☐ NO Does this child have an ongoing health concern? (asthma, diabetes, etc.) If "yes", please describe:

☐ YES ☐ NO Does this child have any allergies? If "yes", please list:

☐ YES ☐ NO Has the allergy required emergency treatment? If "yes", please explain:

☐ YES ☐ NO Are the child's immunizations up to date?

Additional immunizations required: Given?

☐ YES ☐ NO Is there a history of any hospitalizations, significant injuries or surgery? If "yes", please describe:

Are there any current medical concerns/injuries?

☐ Head ☐ Eyes/Glasses ☐ Nose ☐ Ears/Hearing
☐ Throat ☐ Neck ☐ Chest ☐ Respiratory
☐ Cardiovascular ☐ Gastrointestinal ☐ Genitourinary ☐ Neurological
☐ Musculoskeletal (include any past fractures, etc.)

☐ YES ☐ NO Does this child take any medication regularly at home?

☐ YES ☐ NO Require medication at school? If "yes", please describe:

Please list any additional concerns or information:

Please indicate any nutritional restrictions:

Who lives with the child in his/her primary household?

☐ YES ☐ NO Does child spend a significant amount of time in another household? If "yes", please describe:

Who has legal custody of this child? Describe any custody arrangements:

☐ I certify that the information provided is accurate to the best of my knowledge, and I give permission to share the health information provided with teachers and staff on a need-to-know basis.

☐ I understand that my child's immunizations must comply with the Immunization Requirements established by the New York State Education Department.

☐ Release of Medical Information: I give permission for the school nurse to obtain the student's health records (including physical exams, screenings, immunizations, and medication orders) from the student's previous school(s) and/or medical care provider(s).

☐ I understand that in the event of a medical emergency, CSAT is authorized to send my child to the nearest hospital and cannot assume responsibility for any expenses incurred.

☐ *By typing your name in the signature field, you are signing this Form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form.*

Parent/Guardian Signature: Date: