Concord Road Elementary School
Health Office
914-231-0854

Susan Caporal, RN

Last Name: _____ First Name:_____DOB:_____ M/F

Telephone #'s:_____ Date of Last Physical Exam: _____

Up-to-Date with Immunizations? Yes/No

Birth History: Place of Birth: _____

Any complications or medical problems at birth?_____

Childhood History:

Any childhood diseases such as Sickle Cell Anemia, Chicken Pox, etc? _____

_____

_____

Any heart problems such as murmur, defect, disease, surgery? _____

_____

Any seizure disorders such as Febrile seizures or Epileptic seizures? _____

_____

Does your child have asthma? _____ If so, does he/she use nebulizer/inhaler? _____

What medication do they use? _____

Any allergies to medication, environment, food, bee sting? _____

If so, do they use Benedryl, Epi-pen? _____

Any vision, speech or hearing problems? _____

Any history of nosebleeds? _____

Any skin problems such as eczema, allergies, etc? _____

Any stomach problems (gastrointestinal)?_____

Any Genitourinary problems?_____

Does your child receive OT or PT services? Yes/No If so, for what reason?_____

_____

_____

Does your child have any emotional, psychological or behavioral problems that are not age appropriate we should be aware of such as anxiety, fears, attention, tantrums?

_____

Any operations, previous injuries or hospitalizations (such as fractures, etc)? _____

_____

Any medication taken regularly at home or to be taken on a daily basis at school? _____

_____

Pre-School:

Has your child attended pre-school? Yes/No If so, name of pre-school: _____

How many years attended? _____

Please list custodial parent/guardian names: _____