Please complete one Health History Record for each **NEW** student.

OHR REUVEN אור ראובן
YESHIVA KETANA

# HEALTH HISTORY RECORD

**STUDENT'S NAME**_____ **DATE OF BIRTH**_____

**ADDRESS**_____ **GRADE**_____

**HOME TELEPHONE** _____ **STUDENT'S BIRTHPLACE**_____

**FATHER'S NAME**_____ **BIRTHPLACE**_____

**MOTHER'S NAME**_____ **BIRTHPLACE**_____

**CHILD'S DOCTOR'S NAME**_____**TELEPHONE**_____

**CHILD'S DENTIST'S NAME** _____**TELEPHONE**_____

**ORTHODONTIS'S NAME** _____**TELEPHONE**_____

**Has pupil had any of the following illnesses? Please give year.**

**Chicken pox**_____
**Tuberculosis**_____
**Pneumonia**_____
**Bronchitis**_____
**Lyme Disease**_____
**Mononucleosis**_____
**Diabetes**_____

**Rheumatic Fever**_____
**Scarlet Fever**_____
**Seizure Disorder**_____
**Heart Disease**_____
**Migraine**_____
**Asthma**_____

**Other**_____

**ALLERGIES TO:**

**Medications**_____
**Seasonal** _____
**Food**_____
_____

**Is there any other phase of the pupil's health that the school should be aware?** i.e. High fevers, serious illnesses heart murmurs, surgeries, serious injuries or any other medical problems that should concern the school._____

_____

_____

**Has your child ever been hospitalized?** _____**If yes, when and why**_____

**Any history of Amblyopia (lazy eye) in the family?** No___Yes___ **Relationship to child**_____
**Has pupil had a vision exam with an eye doctor?** No___Yes___ **Date**_____
**Does pupil wear glasses?** No___Yes___ **When was present lenses received?** ____
**Has pupil seen an eye doctor for any other eye condition?** No___Yes___ **Describe** _____
**Does pupil have any speech problems?** No___Yes___ **Has there been any speech therapy?** ____
**Has pupil received any Dental Care?** No___Yes___
**Orthodontia (braces)** No___Yes___

**Additional information or comments:** _____

_____

_____

**Parent/guardian** _____**Date**_____

***Please submit by mail, fax (845-357-9593) or email (businessoffice@darcheinoam.org).***