HARLEM INTERNATIONAL COMMUNITY SCHOOL (HICS)
302 WEST 124th STREET, NEW YORK, NY 10027
tel: 212 222-7798 - Email:harlemschool124@yahoo.com
www.harlem-school.com
LOVE + KNOWLEDGE = GROWTH

HEALTH RECORD FOR STUDENTS

Parents are to complete the health record side of this form for each child registered in the school.

Child's Name _____ Date of Birth _____ Gender_____
First Last MM/DD/YYYY

Mother/Guardian Name_____ Father/Guardian Name_____

Home Address _____ _____
Street City Zip Code Street City Zip Code

Home Phone Number _____ Home Phone Number _____

Work Address_____ _____
Street City Zip Code Street City Zip Code

Work Phone Number _____ Work Phone Number _____

Names and ages of children in family_____

Persons Authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary. _____
_____

Family Physician _____ Phone Number_____

Hospital Preference (for emergencies)_____

1. Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments, that can be given by the day care provider? _____ No _____ Yes, as follows
_____

2. Does your child have any of the following conditions? Please answer with a yes or no.
_____ Allergies _____ Frequent sore throats/colds _____ Ear Aches
_____ Skin Problems _____ Other _____
If yes answered to any of the above, please provide additional information _____

3. Have there been any major changes at home that might affect your child in care? _____ No _____ Yes, as follows_____

4. Please provide additional information or special instructions that will help the person caring for your child _____
_____

5. **Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY.**

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

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HEALTH ASSESMENT FOR STUDENTS

The health assessment side of this form is to be completed and signed by a nurse approved by the New York Department of Health or a Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____

PHYSICAL EXAMINATION:

HEIGHT _____ WEIGHT _____

HEAD _____ ABDOMEN _____

EENT _____ GU _____

TEETH _____ GYN _____

HEART _____ SKELETAL _____

LUNGS _____ NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS)

VISION _____ TBC. TEST _____

HEARING _____ SICKLE CELL _____

SPEECH _____ HGB. _____

DDST _____ U.A. _____

OTHER _____

DIAGNOSIS:

RECOMMENDATION:

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION: YES _____ NO _____

_____ _____
Signature of Licensed Physician or Nurse Approved for Child Health Assessments Date (MM/DD/YYYY)

_____ Phone #_____
Print the Name of the Individual Signing Above

_____
Address of Physician or Nurse City Zip Code