



The Clearpool Education Center

Over 100 Years of Learning Beyond the Classroom

33 Clearpool Rd • Carmel, NY 10512 • Phone: (845) 225-8226 • Fax: (845) 225-6337

Health History Form

Please Print Child's Full Name:

Date of Birth _____

Age _____

Male/Female (circle one)

Group attending Clearpool with (school, organization) _____

Grade _____

Emergency Contact Information

Parent/Guardian

Name _____

Home Address _____

Phone (h) _____ (w) _____ (c) _____

Physician/Clinic Name _____

Telephone _____

Health Insurance Name _____

Address _____

Insurance Number _____

Second Emergency Contact

Name _____

Relationship to child _____

Home Address _____

Phone (h) _____ (w) _____ (c) _____

Health History

Does your child have any problems with the following: Circle yes or no

Asthma	yes	no	Environ. Allergies	yes	no
Seizures	yes	no	Allergy to Insect Bites	yes	no
Diabetes	yes	no	Hearing Loss	yes	no
Heart problems	yes	no	Strenuous Exercise	yes	no
Sleepwalking	yes	no	High Blood Pressure	yes	no
Bed Wetting	yes	no			

If yes, please explain:



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Does your child have any other serious medical problems or been under a physicians care recently? If yes explain _____

Does your child have any allergies to food? _____

Diet restrictions? _____

Allergies to medications? _____

Has your child received all required immunizations? Yes No

What was the date of your child's last TETANUS shot? _____

Height _____ Weight _____

Allergies (please specify) _____

Immunizations (please include dates)

DT, DPT _____ Measles #1 _____ Measles #2 _____

Polio _____ Hep B #1 _____ Hep B #2 _____

Hep B #3 _____ MMR _____ Varicella _____

HIB _____ Other _____

Medications:

The student may not have any medications (pill or oral liquid) in his/her possession. This includes over-the-counter medications like Tylenol. All medications must be given to and be held by a school representative or the nurse, who will administer it according to the written instructions. All medications must be in the original pharmacy container.

Prescribed Medication _____

My child may have the following medication if needed:

Tylenol _____ Cough Medicine _____ Antacid _____ Benadryl _____

Any Restrictions

Swimming: (yes or no)

Diving: (yes or no)

Athletic Activities: (yes or no)

Recreation:(yes or no)

Additional comments regarding restrictions: _____

Parent/ Guardian Signature: _____ Date: _____