Scarsdale Student Transfer Education Plan
Health Form

Name	
Date of Birth	
Age	

A. Student Medical History (use separate page if you need additional space)

Have you ever had a major or chronic illness? Yes/No
If so, please explain:

Have you ever been hospitalized? Yes/No
If so, please state when and for what reason:

Have you ever had surgery? Yes/No
If so, please state when and for what reason:

Have you ever had any serious injury? Yes/No
If so, please explain

Have you ever seen a therapist or other mental health professional for emotional difficulties or issues of any sort, (including but not limited to ADHD, anxiety, or depression)? Yes/No
If so, please explain (include circumstances, time frame, dates of treatment, etc.

A. Student Medical History (continued)

Have you ever been diagnosed with the following? (If yes, explain on separate page)

Anemia	Yes/No	Pneumonia	Yes/No
High blood pressure	Yes/No	Severe eczema	Yes/No
Sickle cell trait	Yes/No	Seizures/convulsions	Yes/No
Asthma	Yes/No	Diabetes	Yes/No
Bronchitis	Yes/No	Recurrent urinary Tract infection	Yes/No
Other	Yes/No		

Have you recently had any of the following? (If yes, explain on separate page)

Recurrent abdominal pain	Yes/No	Excessive fatigue	Yes/No
Unusual weight loss	Yes/No	Unusual rashes	Yes/No
Frequent headaches	Yes/No	Joint pain or swelling	Yes/No
Diarrhea	Yes/No	Excessive bleeding	Yes/No
Vomiting	Yes/No	Other	Yes/No

Do you wear glasses or contact lenses? Yes/No
Do you see a dentist regularly? Yes/No If yes, date of last visit: _____
Do you wear orthodontic braces? Yes/No

Medications

Are you currently on any medications: (include over-the-counter medications & supplements)	Yes/No If yes, list:
Do you use any emergency medications such as an inhaler or EpiPen?)	Yes/No If yes, list:

Allergies

Do you have any food allergies?	Yes/No If yes, list:
Do you have allergies to medications?	Yes/No If yes, list:
Other allergies:	Yes/No If yes, list:

For Female Students:

At what age did you start menstruating?	
How often is your period and how long does it last?	
Do you take medication for menstrual cramps?	
Have you ever had to miss school because of menstrual cramps?	

B. Family History

Has your mother had any serious illness?	Yes/No If yes, list:
Has your father had any serious illness?	Yes/No If yes, list:
Have any of your siblings had any serious illness?	Yes/No If yes, list:
Any other illness or diseases that run in your family? (include family history of alcohol or drug abuse)	Yes/No If yes, explain:

C. Physician Health Form, Immunization Record and Dental Health Certificate

Please see the links on our website (www.scarsdalestep.com) under the Student Scholarship tab for these additional forms:

- Physical Examination Form -please print this form and have your doctor complete it.
- Immunization Records. Your doctors own form must be used to document immunizations and should be attached to the physical examination form. See the link for a list of NY State required immunizations.
- Dental Health Certificate-It is requested that you print out this form and have your dentist complete it.

D. Permission and Signatures

I give the STEP Physician and/or Dentist permission to review these forms, and to contact the physician and dentist given below to discuss information on the student:

Name of Student's Physician: _____
Address: _____
Physician's Phone Number: _____

Name of Student's Dentist: _____
Address: _____
Dentist's Phone Number: _____,

To the best of my knowledge all information provided on this form is accurate:

_____ _____
Student Signature Date

_____
Print Student Name

_____ _____
Parent Signature Date

_____
Print Parent Name Revised March 2016