

**Career and Technical Education
Innovative Programs
Alternative Education**



Northern Catskills Occupational Center
2020 Jump Brook Road, PO Box 382
Grand Gorge, NY 12434
(607)-588-6291 Fax: (607)-588-6808

Dear Parent/Guardian:

Please complete and return the Student Health History Update form. The other attached form is to be filled out **by your health care provider** and by the parent/guardian of the child to receive **ANY** medication, prescription or over the counter, while attending classes at NCOC.

Please note that the US Department of Education considers Benadryl, Ibuprofen, Tylenol, Inhalers, etc., illegal to be administered without the attached forms completed by a doctor and parent/guardian. We apologize for the inconvenience.

For medication that is filled by the pharmacist, please ask for an additional labeled bottle to use for the medication that is kept at NCOC.

Medication that is improperly labeled will **NOT BE GIVEN**. Medication that is brought to NCOC that is properly labeled and accompanied by the physician's request with parental permission is the only medication that will be given. If the school nurse at the student's component school has the information, it can be faxed or emailed to me at the NCOC Health office.

If at the time of your doctor visit you do not have a physician request form, ask the doctor to state on a prescription pad the name of the medication, dosage, time to be administered at NCOC and the child's name.

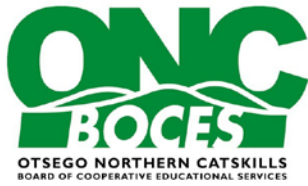
ALL absences must be reported with a note, phone call, or by email by the parent/guardian to me at jdegarmo@oncboces.org in order for your child to have legally excused absence within 5 days of the absence. The easiest way to notify me is via email. Phone calls must be followed up with a signed note or email.

If you have any questions or concerns regarding this, please feel free to call me at (607) 588-6291 ext. 1213.

Respectfully,

Johnny DeGarmo

Johnny DeGarmo, LPN
NCOC Health/Attendance Officer



STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: <small>(person completing this form)</small>	Home Phone:	Date:	
		Cell Phone:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies:			<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalization			
Had an operation			
Had an injury requiring an Emergency Room visit			
Missed 5 days of school in a row due to illness/injury			
Had a bone/muscle injury			
Passed out, had a concussion or serious head injury			
Had a convulsion/seizure			
Had a vision problem or condition			<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition			<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece			
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack			
Had other serious health problems			

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Dental Injuries
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, | anxiety, OCD, ODD, etc.)
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Urinary Condition |
|--|---|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school			
Taken at home			
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school			<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school			<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____