Health History

130-30 31st Ave., Flushing, NY 11354 - (718) 461-4409 - Fax: (718) 461-7368

Student Name _____ DOB _____
Address _____City _____ Zip _____
Emergency Contact Name _____ Phone _____
Relationship to Student _____ Date of Last Physical _____

#	QUESTION	YES	NO
1.	Ever hospitalized?	❒	❒
2.	Ever had major surgery?	❒	❒
3.	Ever had a serious injury?	❒	❒
4.	Takes medication daily? (if yes, what?) ……	❒	❒
5.	Requires medication at school? ……	❒	❒
6.	Heart disease, murmur, irregular heart beat	❒	❒
7.	Seizures	❒	❒
8.	Vision problems (color blindness, glasses or contact lenses)	❒	❒
9.	Frequent earaches (dates)	❒	❒
10.	Frequent sore throat	❒	❒
11.	Liver/kidney disease or enlarged organs	❒	❒
12.	Athsma or lung disease (carries inhaler?)	❒	❒
13.	Any bleeding tendency, blood disease, anemia	❒	❒
14.	Any allergies (bee sting, food, latex, medication)…… Has allergy required emergency medical treatment? ……	❒	❒
15.	Diabetic or glycemic	❒	❒
16.	Ever had a loss of consciousness, fainting, concussion, or frequent headaches	❒	❒
17.	Severe or recurrent chest pains	❒	❒
18.	Difficulty breathing	❒	❒
19.	Impaired use of arms or legs	❒	❒
20.	Nosebleeds	❒	❒
21.	Constipation and/or diarrhea	❒	❒
22.	Bed wetting	❒	❒
23.	Skin condition	❒	❒
24.	Has consulted with a physician in the past 6 months about any condition not listed above?	❒	❒
25.	Has any condition that may be worsened by sports or physical education?	❒	❒
26.	Has any condition that would be considered life-threatening?	❒	❒
27.	Has severe or chronic condition that requires special accommodations in a school setting?	❒	❒
28.	Any dental appliances (braces, retainers, etc.)?	❒	❒
29.	Any serious illness, injury, operation or communicable disease since September of last year?	❒	❒

Please explain "Yes" answers to the above questions and give dates. _____
_____
_____

Explain all "Yes" answers. Give dates.

Diseases	YES	NO			YES	NO
Chicken Pox	❒	❒		Rheumatic Fever	❒	❒
Ear Infections (frequent)	❒	❒		Rubella	❒	❒
Hepatitus A or B	❒	❒		Scarlet Fever	❒	❒
Measles	❒	❒		Strep Throat (frequent)	❒	❒
Mononucleosis	❒	❒		Tuberculosis	❒	❒
Mumps	❒	❒		Whooping Cough	❒	❒

Conditions	YES	NO			YES	NO
Asthma	❒	❒		Hernia	❒	❒
Arthritis	❒	❒		Language Disorder	❒	❒
Blood Disorder	❒	❒		Loss of Paired Organ	❒	❒
Cystic Fibrosis	❒	❒		Menstrual Problems	❒	❒
Cerebral Palsy	❒	❒		Muscular Dystrophy	❒	❒
Chronic Illness	❒	❒		Neurological Problems	❒	❒
Dental Problems	❒	❒		Orthopedic Problems	❒	❒
Diabetes	❒	❒		Rheumatic Fever	❒	❒
Eating Disorder	❒	❒		Scoliosis	❒	❒
Emotional Problems	❒	❒		Sickle Cell Anemia	❒	❒
Heart Defect	❒	❒		Other (Specify)	❒	❒

Difficulty with: Eating ❒ Hearing ❒ Speaking ❒ Swallowing ❒ Vision ❒ Walking ❒

Please explain "Yes" answers to above questions (Give Dates) _____

_____

_____

_____

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Medication Information

PLEASE NOTE: *Any medication given at school (prescription or non-prescription) requires parent authorization and a parent must deliver medication in a labeled bottle to the school office.*

This health history is correct and my child has permission to engage in school activities unless noted by the physician or me. In the event of an emergency in which my spouse, my physician and I cannot be reached, I give permission to the physician or hospital selected by the school to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above with the understanding that the family will be notified as soon as possible.

Student's Name: _____

Parent/Guardian Signature: _____

Relationship to Student: _____

Date: _____