HEALTH HISTORY
TO BE COMPLETED BY PARENT

Revised 8/16/2013

STUDENT'S NAME _____ **GRADE** _____ **D.O.B.** _____

Has your child ever had: (Please check)

	YES	NO		YES	NO
Medication Allergies	( )	( )	Injury to Spleen	( )	( )
Environmental Allergies	( )	( )	Infectious Mononucleosis	( )	( )
Food Allergies	( )	( )	Fracture/of any bone	( )	( )
Bee sting Allergy	( )	( )	Joint Dislocation/Injury	( )	( )
Asthma	( )	( )	Ligament Injury	( )	( )
Anemia	( )	( )	Torn/Pulled Muscle	( )	( )
Arthritis	( )	( )	Back Pain/Injury	( )	( )
Bladder/Kidney problems	( )	( )	Neck Injury	( )	( )
Cancer	( )	( )	Knee Pain/Injury	( )	( )
Convulsions/Seizures	( )	( )	Ankle Pain/Injury	( )	( )
Rheumatic Fever	( )	( )	Prosthetic Appliance	( )	( )
Diabetes	( )	( )	Operations	( )	( )
Ear Problems/Hearing Loss	( )	( )	One Kidney	( )	( )
Vision in only one eye	( )	( )	One Testicle	( )	( )
Contact Lenses	( )	( )	Orthopedic Appliance	( )	( )
Emergency Room Visit	( )	( )	Stomach Ulcer	( )	( )
Fainting Spells	( )	( )	Sudden Weight Loss/Gain	( )	( )
Headaches/Frequent or Severe	( )	( )	Ill for 5 Consecutive Days	( )	( )
Hospitalization	( )	( )	Frequent Absences/lateness	( )	( )
Tuberculosis	( )	( )	Immunizations up to date?	( )	( )
Pneumonia	( )	( )			
Congenital defect	( )	( )	<u>FOR GIRLS ONLY</u>		
			Menstrual Period	( )	( )
			If yes, age started	_____	
			If yes, Heavy Bleeding	( )	( )
			If yes, Cramps	( )	( )

If yes to the above questions, please provide details: dates, physician, treatment, immunization updates, and current status of problem:

	YES	NO
1. Does your child have a history of any of the following:		
• Unexplained fainting or near fainting	( )	( )
• Chest pain/discomfort upon exertion	( )	( )
• Excessive and unexplained fatigue associated with exercise	( )	( )
• Heart murmur (other than innocent murmur)	( )	( )
• High blood pressure	( )	( )
2. Is there a family history of any of the following:		
• One or more relatives who died of heart disease (sudden/unexpected or otherwise) before age 50	( )	( )
• Close relative under age 50 with disability from heart disease	( )	( )
• Specific knowledge of certain cardiac conditions in family members including hypertrophic or dilated cardiomyopathy	( )	( )
• Long QT syndrome, Marfan syndrome or clinically important arrhythmias	( )	( )

IF YOU ANSWER YES TO ANY OF THE ABOVE TWO QUESTIONS, YOUR CHILD MUST RECEIVE CARDIAC CLEARANCE

Has your child been unconscious or lost memory from a blow on the head? ( ) ( )

Is there any other information that the school should know in order to safeguard your child's health?

_____

_____

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature: _____ **Date:** _____