

STUDENT HEALTH HISTORY FORM

Student Name: _____ Grade/Age: _____

Family Medical Insurance: _____

Full Term Pregnancy: ____ Yes ____ No

Birth Weight: _____

Complications During Pregnancy/Birth: _____

Family Doctor: _____

Phone: _____

Family Dentist: _____

Phone: _____

Serious Injuries, Operations, Illnesses including Dates: _____

Asthma: ____ Yes ____ No Medication Required: _____

Does student have or ever had:

	<u>YES/Dates</u>		<u>YES/Dates</u>
Chicken Pox	<input type="checkbox"/> _____	Contact W/Tuberculosis	<input type="checkbox"/> _____
Measles	<input type="checkbox"/> _____	Rheumatic Fever	<input type="checkbox"/> _____
Mumps	<input type="checkbox"/> _____	Diabetes	<input type="checkbox"/> _____
Scarlet Fever	<input type="checkbox"/> _____	Hepatitis	<input type="checkbox"/> _____
Whooping Cough	<input type="checkbox"/> _____	Pneumonia	<input type="checkbox"/> _____
Allergies	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/> _____
Frequent Cold/Sore Throat	<input type="checkbox"/> _____	High Fevers	<input type="checkbox"/> _____
Frequent Earaches (which ear)	<input type="checkbox"/> _____	Seizures	<input type="checkbox"/> _____

If YES, Please Provide Details: _____

Does student have or ever had a problem related to:

YES/Dates

YES/Dates

Vision: _____
Dental _____
Neurological _____

Headaches
Orthopedic
Emotional

If YES, Please Provide Details:

YES NO

- Has student ever passed out during exercise or stopped due to dizziness?
 Does student have asthma (wheezing), hay fever or coughing spells after exercise?
 Has the student ever broken a bone, had to wear a cast or had any injury to any joint?
 Has the student ever had a concussion or been knocked unconscious?
 Has the student ever suffered heat related illness (Heat Stroke)?
- Does the student have a chronic illness or see a physician regularly for any particular problems?
 Does the student take any medication?
- Is the student allergic to any medications, bee stings or foods?
- Has the student missed 5 consecutive days of school, phys. Ed. Or sports due to injury or illness?
 Does the student wear glasses/contact lenses?
 Has the student ever been hospitalized or had surgery?
- Does the student live with anyone who is immunosuppressed or suffering from a chronic illness?
 Do you have anything you would like to discuss with the school nurse?

If YES, Please Provide Details:

Parent Signature/Phones: _____ Date:

121 Lincoln Place * Liberty, NY 12754
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HYPERLINK "http://www.stpetersliberty.org" www.stpetersliberty.org

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