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All Students. All of the Time

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Grade:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone:	Cell Phone:		Date:
For Athletes in Grades 5-12		Sport:	School:	

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

CHECK ALL THAT APPLY TO YOUR CHILD:

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

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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: _____

This sample resource was created by the New York Statewide School Health Services Center and is located at