HEALTH HISTORY

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT'S NAME_____GRADE_____
COUNTRY OF STUDENT'S BIRTH_____ SEX_____

PLEASE ANSWER EACH QUESTION BY CIRCLING "Y" FOR YES OR "N' FOR NO

1. Has the student ever been hospitalized?	Y	N
2. Has the student ever had surgery?	Y	N
3. Is the student currently on any medication (daily or occasionally)?	Y	N
4. Does the student have allergies to medications, foods, or insects?	Y	N
5. Does the student have an Epi-Pen for severe allergic reactions?	Y	N
6. Has the student ever passed out?	Y	N
7. Has the student ever been dizzy during exercise or in the heat?	Y	N
8. Has the student ever had chest pain during or after exercise?	Y	N
9. Has the student ever had high blood pressure?	Y	N
10. Have you ever been told that the student has a heart murmur?	Y	N
11. Has the student ever had a racing heart or skipped heart beats?	Y	N
12. Has anyone in the student's family died of heart problems or sudden death before the age of 50?	Y	N
13. Does the student have any skin problems under treatment?	Y	N
14. Has the student ever had a head injury or concussion?	Y	N
15. Does the student have any problem with ears or hearing loss?	Y	N
16. Does the student have trouble breathing during or after exercise?	Y	N
17. Does the student have asthma?	Y	N
18. Does the student have any asthma inhaler or nebulizer treatments?	Y	N
19. Has the student had any problem with eyes or vision?	Y	N
20. Does the student wear glasses or contact lenses?	Y	N
21. Does the student have any medical conditions?	Y	N
22. Does the student have any mental health or behavioral conditions?	Y	N
23. Has the student ever suffered a fracture or dislocation?	Y	N
24. Does the student wear orthodontic braces or a retainer?	Y	N
25. Has the student ever had chicken pox, otitis media, strep infections, mononucleosis, lyme disease, or rheumatic fever?	Y	N

PLEASE EXPLAIN ALL "YES' ANSWERS INCLUDING DATES

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I give permission for the school nurse to share my child's pertinent medical information with the administration and school personnel working directly with him/her. Beyond that, I understand that all of my child's medical information will be kept confidential. The information I have provided is accurate to the best of my knowledge. I give the school nurse permission to contact my child's physician for further details if needed.

Signature of Paent/Guardian_____Date_____