

MINISINK VALLEY CENTRAL SCHOOL
Slate Hill, NY 10973

Health History for School Year 20 ____ - 20 ____

Dear Parent:

When your child enters school, we establish a cumulative health file for him/her to enable us to have a greater understanding of your child's needs. All information will be kept confidential, so please answer every question. Thank you.

PLEASE PRINT NEATLY. Thank you for your cooperation.

Student's Name: _____ Male / Female Age: _____ Grade: _____

Date of Birth: _____ School: _____ Home Phone Number: _____

Physician: _____ Dr's Phone Number: _____ Dr's Fax Number: _____

Child lives with (fill in only what applies):

Mother's Name: _____ Father's Name: _____

(Other) Name and Relationship to child: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Directions: Please answer the following questions about the student's medical history. Explain all "yes" responses on the back of this page. Please respond to all questions.

1. Has your child had or currently have:
 - a. An injury or illness since your last exam y / n / don't know
 - b. A chronic or ongoing illness (such as diabetes or asthma) y / n / don't know
 1. Use an inhaler or other prescription medicine to control asthma? y / n / don't know
 - c. Any prescribed or over the counter medications that you take on a regular basis? y / n / don't know
 - d. Surgery, hospitalization or any emergency room visit(s)? y / n / don't know
 - e. Any allergies to medications? y / n / don't know
 - f. Any allergies to bee stings, pollen, latex or foods? y / n / don't know
 1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)
 2. Take any medication/Epi pen taken for allergy symptoms? (List on back.)
 - g. Any anemias or blood disorders? y / n / don't know

2. Has your child had or currently have any of the following head-related conditions since your last physical:
 - a. Concussion requiring a physician's evaluation? y / n / don't know
 1. How often and when? (Answer on back page.)
 - b. Memory loss or been knocked out? y / n / don't know
 - c. A seizure? y / n / don't know
 - d. Frequent or severe headaches? y / n / don't know
 1. Medication required? (List on back)

3. Has your child had or currently have any of the following heart-related conditions since your last physical:
 - a. Chest pain? y / n / don't know
 - b. Heart murmur? y / n / don't know
 - c. High blood pressure or elevated cholesterol level? y / n / don't know
 - d. Restriction from sports for heart problems? y / n / don't know

4. Has your child had or currently have any of the following eye, ear, nose, mouth or throat conditions since your last physical:
- a. Vision problems? y / n / don't know
 - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.)
 - b. Hearing loss or problems? y / n / don't know
 - 1. Wear hearing aides or implants? y / n / don't know
 - c. Nasal fractures or frequent nose bleeds? y / n / don't know
 - d. Wear braces, retainer or protective mouth gear? y / n / don't know
 - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? y / n / don't know

**It is advised that every child wearing eyeglasses should receive periodic eye examinations. The school would appreciate a report of exam and name of examiner together with his/her recommendations for the school.*

5. Has your child had or currently have any of the following neuromuscular/orthopedic conditions since your last physical:
- a. Upper or lower back pain? y / n / don't know
 - b. Fracture(s) or stress fracture(s)? y / n / don't know
 - c. Do you wear any protective braces or equipment for any prior injury? y / n / don't know

6. Has your child had or currently have any of the following general or exercise related conditions since your last physical?
- a. Difficulty breathing? During exercise? (Circle one.) y / n / don't know
 - 1. After running one mile y / n / don't know
 - 2. Coughing, wheezing or shortness of breath in weather changes? y / n / don't know
 - 3. Exercise-induced asthma y / n / don't know
 - i. Controlled with medication? (List below.) y / n / don't know
 - ii. Experience dizziness, passing out or fainting? y / n / don't know
 - b. Viral infections (e.g. mono, hepatitis)? y / n / don't know
 - c. Any of the following skin conditions: y / n / don't know
 - 1. Acne, contact dermatitis, ringworm, warts, herpes? y / n / don't know
 - 2. Sun sensitivity? y / n / don't know
 - d. Weight gain/loss (greater than or less than 10 pounds)? y / n / don't know
 - e. Ever had feelings of depression? y / n / don't know
 - f. Heat-related problems (dehydration, dizziness, fatigue, headache)? y / n / don't know
 - 1. Heat exhaustion (cool, clammy, damp skin)? y / n / don't know
 - 2. Heat stroke (hot, red, dry skin)? y / n / don't know

7. Females only:
- Age of onset of menstruation:
 - Date of last menstruation:
 - Most number of days between menstruation cycle(s):

Explain all "yes" answers here (include relevant dates):

YOU MUST BRING PROOF OF IMMUNIZATIONS AT TIME OF REGISTRATION IN ORDER TO REGISTER A STUDENT.

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature: _____ Date: _____