MINISINK VALLEY CENTRAL SCHOOL
Slate Hill, NY 10973

Health History for School Year 20___ - 20___

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

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 print clearly and answer every question. Thank you.

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

Address: _____

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: _____

PHYSICAL REQUIRED for all students entering grades 1 through 12.
(Note: Entering kindergarten students MUST have the physical done by their private physician.)

☐ I will be having the physical done by my private physician.

☐ I give permission for the school's physician to do the required physical.

Parent/Guardian Signature: _____ Date: _____

Directions: Please answer ALL of the following questions about the student's medical history. 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) y / n / don't know

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:
        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" (include relevant dates) below and on the back of this page, if needed.

_____

_____

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: _____