Sherburne-Earlville Middle/High School Health Office

HEALTH HISTORY

Phone: 674-7310/7314 Fax: 674-7383

TO BE COMPLETED, SIGNED BY PARENT/GUARDIAN and RETURNED TO THE HEALTH OFFICE!

Name: ______________________________ **Date of Birth** ______________ **Grade**____

Date of last Physical Exam:

Please check the season(s) you intend to play a sport:
☐ *Fall* ☐ *Winter* ☐ *Spring*

ImPACT Test Date:

☐ **Your child needs to have a *physical* for the upcoming sports season.**
◆ ***A current physical must be on file in the Health Office to be eligible to participate in sports.***

☐ According to New York State guidelines, **new entering students, 7th and 10th graders are required to have a physical.** Please complete and return this form to the Health Office. ***A current physical must be on file.***

☐ **Physical Fitness Certification for Employment** ***(Working papers request)***

Parent: Please check (✓) one of the following:

☐ **My child will have his/her physical with *primary health care provider.** * **Date of appointment**____________________

☐ **My child will have a physical at the School Based Health Center (SBHC).*** **Date of appointment** ____________________

* ***A copy of the exam must be sent to the Health Office for the student's health file.***

✑ ✑ ✑ **Does your child have, or has he/she ever had:** ***(please check or circle where appropriate)***

	Yes	No		Yes	No
Seasonal Allergies/ Hay Fever	☐	☐	**Allergy requiring Epipen? (Food, latex, other)**	☐	☐
Bee Sting Allergy -Explain severity-***requires Epipen?***	☐	☐	Heat cramp/ Heatstroke	☐	☐
Asthma- uses an Inhaler?	☐	☐	Headaches (or headache with exercise?)	☐	☐
Anemia	☐	☐	Hernia	☐	☐
Arthritis	☐	☐	**Heart Problem/** Murmur/ Chest Pains	☐	☐
Bladder / Kidney Problem or Injury	☐	☐	Felt irregular heart beat, palpitations, fluttering	☐	☐
One kidney or one functioning kidney	☐	☐	Exercised induced chest pain/pressure	☐	☐
Fainting Spells, dizziness, syncope	☐	☐	A pacemaker	☐	☐
Bleeding disorder	☐	☐	EKG, stress test or echocardiogram	☐	☐
Ear Problems/ **Hearing Loss/Hearing Aid**	☐	☐	A special diet or avoided certain foods	☐	☐
Eye glasses/Contact lens/ **Protective eye gear**	☐	☐	A worry about his/her weight	☐	☐
Eye Problems/ One Eye/**Vision Loss**	☐	☐	Brace or orthotic device	☐	☐
Fractured nose	☐	☐	**Diabetes**	☐	☐
Nose bleeds, frequent or severe	☐	☐	Hypoglycemia	☐	☐
Orthodontic device	☐	☐	Injury to spleen	☐	☐
Chipped Tooth/teeth, capped tooth/teeth	☐	☐	Convulsions/**Seizures/Epilepsy**	☐	☐
Stomach Ulcer/stomach problems	☐	☐	***Males only***: Only One Testicle	☐	☐
Rashes, sores, or skin problems	☐	☐	Marfan Syndrome	☐	☐
Rheumatic Fever	☐	☐	Sickle cell trait or disease	☐	☐
Food allergies?____________________	☐	☐	Mononucleosis (mono) Date: ____________	☐	☐
Medication allergies?________________	☐	☐	Chicken Pox: Date ________________	☐	☐

Please see other side ➔

Girls only: Age of onset of menstrual period _______ How many times in the past year? _______ Are periods regular? Yes ☐ No ☐

Has a doctor ever told you that you have: ☐ High or low blood pressure ☐ high cholesterol ☐ heart murmur ☐ heart infection

Has your child ever had an <u>injury</u> like a sprain, strain, muscle or ligament tear, tendinitis, broken bone, stress fracture, a dislocated joint or any injury that required *x-rays, MRI, CT, surgery, physical therapy, a brace, a cast, crutches or a stay in the hospital*? If yes, check:

☐ *Head* ☐ *Upper back* ☐ *Lower back* ☐ *Upper Arm* ☐ *Elbow* ☐ *Forearm* ☐ *Wrist* ☐ *Hand/fingers* ☐ *Chest*

☐ *Neck* ☐ *Shoulder* ☐ *Hip* ☐ *Thigh* ☐ *Knee* ☐ *Calf/shin* ☐ *Ankle* ☐ *Foot/toes*

	Yes	No
Is your child assigned to the *Adaptive Physical Education Program* ____________	☐	☐
or, **has he/ she *ever* been** in the *Adaptive Physical Education Program?* ____________	☐	☐
Has your child *ever* had an **illness, condition, or injury** that required him/her to go to the hospital, either as a patient overnight, or required an operation? If so, explain ____________	☐	☐
Has your child ever had an **operation** (surgery)? ____________	☐	☐
Has your child been unconscious or experienced memory loss from a blow to the head? ____________	☐	☐
Has your child ever been diagnosed with a head injury or <u>concussion?</u> (Date _________) ____________	☐	☐
Has your child ever complained of **lightheadedness or dizziness** during or after exercise? ____________	☐	☐
Has your child had **severe cramping or illness** when exercising in the heat? ____________	☐	☐
Has your child ever complained of **chest pressure, shortness of breath, wheezing or coughing during or after exercise**? _______	☐	☐
Has your child ever **fainted** during exercise? If so, explain: ____________	☐	☐
Has your child ever had **tingling, numbness, weakness** or unable to move his/her arms or legs after a hit or a fall? ____________	☐	☐
Has your child taken ***any medication in the past year?*** If so, explain: ____________	☐	☐
Is your child taking **any medication now?** If so, explain: ____________	☐	☐
Is your child under **medical care now**? ____________	☐	☐
Does your child have any ***learning or attention* problems?** ____________	☐	☐
Does your child have any ***behavior, emotional or mental health problems*?** If so, explain: ____________	☐	☐

<u>Family History:</u>

◆ Has there ever been a sudden death in a family member **under the age of fifty (50)**? .... If so, explain: ____________	☐	☐
◆ Does any **relative** have a serious illness? If so explain........	☐	☐

◆ Has any relative had the following, under the age of 55? ☐ **Asthma** ☐ **Diabetes** ☐ **Heart disease** ☐ **Stroke** ☐ **Marfan syndrome** ☐ **Cardiomyopathy** ☐ **Long QT or Short QT syndrome** ☐ **Brugada syndrome** ☐ catecholaminergic polymorphic ventricular tachycardia

◆Since your child's **<u>last physical examination</u>**, *has your child had any injury or medical illness?* .... *If so, explain:* ____________	☐	☐
◆***Do you have any worries about your child's health or other questions you would like to discuss with a doctor?* …………** *If so, explain:* ____________	☐	☐

To the best of my knowledge, the above statements are accurate.

✦***Parent/Guardian* signature** ____________________ **Date**__________

❑ *I give permission for a physical exam to be done at the Bassett School Based Health Center (SBHC).*
<u>Parent/Guardian may call 674-8416 to schedule this appointment</u>…

✦***Parent/Guardian* signature**____________________ **Date** __________