Sherburne-Earlville Middle/High School Health Office

✚ ✚ ✚ ✚ ✚ HEALTH HISTORY ✚ ✚ ✚ ✚ ✚

Phone: 674-7310/7314 Fax: 674-8415

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Name: ______________________________ **Date of Birth** ___________ **Grade**_____

Date of last physical

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

☐ Your child needs to have a sports ***physical*** for the upcoming season. ***His/her physical will be scheduled when this Health History form is completed, signed and returned to the Health Office.***
◆***A current physical must be on file 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 ***as soon as possible*** 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 physician*. Date of appointment__________________**
◆ ***A copy of the exam and completed Health History must be sent to the Health Office for the student's health file.***

☐ **My child will have a physical at the Bassett School Based Health Center.**

✑ ✑ ✑ **Has your child *ever* had:** ***(please check or circle where appropriate)***

	Yes	No
Seasonal Allergies/ Hay Fever	☐	☐
Bee Sting Allergy (Explain severity)	☐	☐
Asthma- uses an Inhaler?	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Bladder / Kidney Problem or *Injury*	☐	☐
Convulsions/ Seizures	☐	☐
Fainting Spells, dizziness, syncope	☐	☐
Diabetes	☐	☐
Elevated Blood Pressure	☐	☐
Ear Problems/ **Hearing Loss**	☐	☐
Eye Problems/ One Eye/**Vision Loss**	☐	☐
Eye Glasses/Contact Lens/Protective Eye gear	☐	☐
Fractured nose	☐	☐
Nose Bleeds/ Frequent or Severe	☐	☐
Injury to the Spleen	☐	☐
Stomach Ulcer	☐	☐
Rashes, sores, or skin problems	☐	☐
Rheumatic Fever	☐	☐
Medication allergies?______________	☐	☐

	Yes	No
Chicken Pox: *(Date _____________)*	☐	☐
Heat cramp/ Heatstroke	☐	☐
Headaches (or headache with exercise?)	☐	☐
Head Injury/ **Concussion**	☐	☐
Heart Problem/ Murmur/ Chest Pains	☐	☐
Felt irregular heart beat, palpitations	☐	☐
Exercised induced chest pain	☐	☐
Ankle Pain/ Injury	☐	☐
Back Pain/ Injury	☐	☐
Knee Pain/ Injury	☐	☐
Neck Injury	☐	☐
Bone or Joint Dislocation or Fracture	☐	☐
Joint Sprain/ Ligament Tear/ Muscle Pull	☐	☐
Orthodontic Appliance	☐	☐
Chipped Tooth/ Teeth, Capped Tooth/Teeth	☐	☐
Only One Kidney	☐	☐
Only One Testicle	☐	☐
Marfan Syndrome	☐	☐
Sickle cell trait or disease	☐	☐
Mononucleosis (mono) *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 blood pressure ☐high cholesterol ☐heart murmur ☐heart infection

Has your child ever had an injury 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 or crutches*? If yes, check below:

☐*Head* ☐*Neck* ☐*Shoulder* ☐*Upper Arm* ☐*Elbow* ☐*Forearm* ☐*Hand/fingers* ☐*Chest* ☐*Upper back*
☐*Lower back* ☐*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, required an operation, or caused your child to miss a game or practice? If so, explain: ___________________________	☐	☐
Is your child under medical care now? ____	☐	☐
Has your child taken *any medication in the past year?* If so, explain: ______________________________	☐	☐
Is your child taking **any prescription medication now?** If so, explain: ______________________________	☐	☐
Has your child been unconscious or experienced memory loss from a blow to the head? ____________________	☐	☐
Has your child ever had numbness, tingling, or weakness in their arms or legs after being hit or falling? _______________	☐	☐
Has your child had severe cramping or illness when exercising in the heat? ______________________________	☐	☐
Has your child ever fainted during exercise? If so, explain: ______________________________	☐	☐
Does your child have any *behavior or mental health problems*? If so, explain: ______________________________	☐	☐
◆ 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, please explain: ______________________________	☐	☐
◆ Has any relative had the following, under the age of 55? ☐**Asthma** ☐ **Diabetes** ☐**Heart disease** ☐ **Stroke**		
Since your child's **last physical examination**, *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: ____

Explain any medical problems here.____

☐ ***I give permission for a physical exam to be done at the Bassett School Based Health Center.***
I understand that if my child is enrolled in the BASE Clinic, my medical insurance will be billed for the exam.

✦***Parent*** **signature**____ Date ______________

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

✦***Parent*** **signature** ____ Date______________