Sherburne-Earlville Elementary School Health Office

HEALTH HISTORY

Phone: 674-7389 Fax: 674-8440

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

Name: _____ Date of Birth _____ Grade____

Date of last Physical Exam:

☐ According to New York State guidelines, **new entering students, Pre-K or Kindergarten, 1st , 3rd, and 5th graders are required to have a physical.** ***A current physical must be on file in the Health Office.***

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.***

	Yes	No
Seasonal Allergies/ Hay Fever	☐	☐
Allergy requiring EPIPEN? Bee, Food, Latex, Other	☐	☐
Asthma- uses an Inhaler?	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Bladder / Kidney Problem or Injury	☐	☐
One kidney or one functioning kidney	☐	☐
Fainting Spells, dizziness, syncope	☐	☐
Bleeding disorder	☐	☐
Ear Problems/ **Hearing Loss/Hearing Aid**	☐	☐
Eye glasses/Contact lens/ **Protective eye gear**	☐	☐
Eye Problems/ One Eye/**Vision Loss**	☐	☐
Fractured nose	☐	☐
Nosebleeds, frequent or severe	☐	☐
Orthodontic device	☐	☐
Chipped Tooth/teeth, capped tooth/teeth	☐	☐
Stomach Ulcer/stomach problems	☐	☐
Rashes, sores, or skin problems	☐	☐
Rheumatic Fever	☐	☐
Food allergies?_____	☐	☐
Medication allergies?_____	☐	☐

	Yes	No
Mononucleosis (mono) Date: _____	☐	☐
Heat cramp/ Heatstroke	☐	☐
Headaches (or headache with exercise?)	☐	☐
Hernia	☐	☐
Heart Problem/ Murmur/ Chest Pains	☐	☐
Felt irregular heart beat, skipped beat, palpitations, fluttering, heart racing	☐	☐
Exercised induced chest pain/pressure	☐	☐
A pacemaker	☐	☐
EKG, stress test or echocardiogram	☐	☐
A special diet or avoided certain foods	☐	☐
A worry about his/her weight	☐	☐
Brace or orthotic device	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Injury to spleen	☐	☐
Convulsions/**Seizures/Epilepsy**	☐	☐
Males only: Only One Testicle	☐	☐
Marfan Syndrome	☐	☐
Sickle cell trait or disease	☐	☐
Have a special device or prosthesis-insulin pump, glucose sensor, ostomy bag etc.?	☐	☐

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 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, 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, or has your child ever been assigned to the *Adaptive Physical Education Program* _____	☐	☐
Has your child ever been restricted by a health care provider from PE/sports for any reason? _____	☐	☐
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 concussion? (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: _____	☐	☐

Family History:

◆ 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 **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: _____

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).*
Parent/Guardian may call 674-8417 to schedule this appointment...

✦***Parent/Guardian*** **signature**_____ **Date** _____