Health History for School Admission

Student Name:	DOB:
Affirmed (preferred) Name (if applicable):	
Sex Assigned at Birth: Female ☐ Male ☐	Gender Identity (if applicable): Female ☐ Male ☐ Nonbinary ☐ X ☐
Primary Care Provider:	Dentist:
Grade:	Date Form Completed:

The school nurse will require a copy of an up-to-date physical completed by a NYS provider on the NYS physical form and copies of immunization records.

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

DOES OR HAS YOUR CHILD

General Health	NO	YES
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Cystic Fibrosis ☐ Scoliosis ☐ Autism ☐ ADHD ☐ Mental Health Condition (Depression/Anxiety, OCD, ODD, etc.) ☐ Other: (Additional medical history can be listed on page 2)		
Take any medication?	☐	☐
If yes, please list name and reason for taking: (Additional medications can be listed on page 2)		
Ever Had Surgery?	☐	☐
If yes, please list: (Additional surgeries can be listed on page 2)		
Spent the night in the hospital?	☐	☐
If yes, why?		
Current injuries/restriction from activity?	☐	☐
If yes, why?		

DOES OR HAS YOUR CHILD

General Health	No	Yes
Have Allergies?	☐	☐
If yes, check all that apply: ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Has a bleeding disorder?	☐	☐
Have a kidney/urinary condition?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Brain/Head Injury History	**NO**	**YES**
Ever been told they had a concussion?	☐	☐
If yes, date of concussion:		
Receive treatment for a seizure disorder or epilepsy?	☐	☐
If yes, type of seizure: ☐ Tonic-Clonic ☐ Focal ☐ Absence ☐ Fever Date of last seizure:		
Ever had migraines?	☐	☐
Breathing	**No**	**Yes**
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
Use an inhaler or nebulizer?	☐	☐

Please continue on page 2 ⇨

Student Name:		DOB:	

DOES OR HAS YOUR CHILD

Heart Health	No	Yes
Heart or blood vessel problem?	☐	☐

If yes, check all that apply:

☐ Chest Tightness or Pain ☐ Heart infection
☐ High Blood Pressure ☐ Heart Murmur
☐ High Cholesterol ☐ Low Blood Pressure
☐ New fast or slow heart rate ☐ Kawasaki Disease
☐ Followed by a cardiologist ☐ Has a pacemaker
☐ Has implanted cardiac defibrillator (ICD)

Other:

Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐

DIGESTIVE (GI) HEALTH	No	Yes
Have stomach or other GI problems?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Has an eating disorder?	☐	☐

DOES OR HAS YOUR CHILD

Skin Health	No	Yes
Have any chronic skin conditions?	☐	☐

If yes, list:

Head, Ear, Nose, Throat	No	Yes
Frequent Ear Infections?	☐	☐
Recurring Strep Throat?	☐	☐

DEVICES / ACCOMMODATIONS	No	Yes
Use a brace, orthotic, wheelchair, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Has your child ever had speech therapy?	☐	☐
Does your child require any medical services at school?	☐	☐
Does your child have any other medical and/or emotional issues?	☐	☐

If YES to any questions, give details/additional information. Sign and date below.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above-named child.

Parent/Guardian Signature:	Date: