Smithtown Christian School

Health Screening/Medical History Form – Grades Pre-K - 12

It is the sole responsibility of the parent and/or guardian to furnish the Health Office with information regarding any change in the health status.

Name:_____DOB:___/___/____ Grade:_____

Parent/Guardian: Answer the following questions as accurately as possible with details if needed.

1. Has student suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime? Yes/ No When? _____ Did loss of consciousness occur? Yes/ No
Describe event:_____

2. Any broken bones, fractures, surgery? Yes/ No When?_____
Describe_____

3. Any other injury requiring medical attention/hospital visit? Yes/ No When?_____
Describe_____
4. History of heart murmur? Cardiac Arrhythmia? Palpitations? Yes/ No Describe_____
_____
5. Asthmatic? Yes/ No Requires an inhaler for sports/exercise? Yes/ No Describe_____
_____

6. Any other chronic diseases or ailments? Yes/ No Describe_____
_____
7. Any fainting/ dizziness/fatigue after exertion? Yes/ No Describe_____
_____

8. Taking Medications at this time? Yes/ No
Describe_____

9. Allergies? Yes/No (Medications, foods, environment, etc.)

Describe_____

10. Glasses/contact lenses: Yes/ No Protective eyewear needed? Yes/ No Orthodontic appliance Yes /No

11. Any other conditions or impairment (vision, speech, hearing, scoliosis, etc.) that the health office should be aware of? Yes/ No
Describe_____

12. Any handicapped conditions or need for special services or therapy? Yes/ No
Describe_____
Parent or Guardian
signature:_____Date:_____