# Hastings-On-Hudson Union Free School District

## STUDENT HEALTH HISTORY

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Age:</th>
<th>Gender: □ M □ F</th>
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<thead>
<tr>
<th>Parent/Guardian: (person completing this form)</th>
<th>Home Phone:</th>
<th>Cell Phone:</th>
<th>Date:</th>
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### Has your child ever:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>If Yes, please explain and include date:</th>
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- Had an ongoing medical condition
- Seen a medical specialist
- Had allergies:
  - □ food  □ environmental  □ insect  □ medication  □ other
  - □ epi-pen
- Had a hospitalization
- Had an operation
- Had an injury requiring an Emergency Room visit
- Missed 5 days of school in a row due to illness/injury
- Had a bone/muscle injury
- Passed out, had a concussion or serious head injury
- Had a convulsion/seizure
- Had a vision problem or condition
  - □ glasses  □ contacts
- Had a hearing problem or condition
  - □ hearing aid  □ cochlear implant
- Worn dental bridge, braces or mouthpiece

### Have any family members under the age of 50 ever:

<table>
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<th>YES</th>
<th>NO</th>
<th>If Yes, please specify:</th>
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- Had a heart attack
- Had other serious health problems

### CHECK ALL THAT APPLY TO YOUR CHILD:

- □ ADHD
- □ Asthma/trouble breathing
- □ Autism/Asperger
- □ Dental Injuries
- □ Diabetes
- □ Ear Infections
- □ GI Conditions (ulcer, reflux, IBS)
- □ Headaches/migraines
- □ Heart Conditions
- □ High Blood Pressure
- □ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- □ Scoliosis
- □ Single Organ (□ kidney, □ testicle)
- □ Skin Condition
- □ Speech Condition
- □ Urinary Condition

### CURRENT MEDICATIONS

<table>
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- Please list name, dose, time(s)

- □ Given at school
- □ Taken at home

### ASSISTIVE EQUIPMENT

<table>
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<th>YES</th>
<th>NO</th>
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- Please check all that apply

- During or outside of school
  - □ crutches  □ walker  □ wheelchair  □ other:

### TREATMENTS

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<th>YES</th>
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- During or outside of school
  - □ insulin/blood glucose monitoring  □ inhaler/nebulizer/peak flow monitoring  □ special diet

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Is there any condition that would prevent your child from participating in physical education or sports?

- □ No  □ Yes: ____________________________________________________________

Please list any additional concerns: (use back of sheet if necessary) ____________________________________________________________

__________________________________________________________

Parent/Guardian Signature: __________________________ Date: __________________________