CENTRAL SQUARE CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Grade:	☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Ph:		Date:
	Cell Ph:		

Contact name and number if your child becomes ill or injured during school hours:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalized	☐	☐	
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:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD: *(Provide doctor's documentation)*

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

Please be aware that a doctor's order is required for all prescription and over the counter medication given at school.

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ special diet

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) _____

_____

NYS law requires a health examination for all students **entering the school district for the first time and when entering Pre-K, K, 1st, 3rd, 5th, 7th, 9th and 11th grade**. Your personal physician or the school physician may do health examines.
Please indicate your preference: ☐ Personal Physician ☐ School Physician (includes testicular exam for males)

The above information may be shared with appropriate school personnel.

Parent/Guardian Signature: _____ Date: _____

Print Name of Parent/Guardian: _____

3/2022