Livonia Central School District
STUDENT HEALTH HISTORY

Name: ____ DOB:___________________________

Address: ____

Contact person in case of emergency: _________________________/___________________/___________________
Name Phone Relationship

E-mail address: ____

Child's Physician: ____/__________________________
Name Phone

Hospital to be called in case of emergency: ____

		YES	NO
1.	Ever hospitalized?	❒	❒
2.	Ever had major surgery?	❒	❒
3.	Ever had serious injury?	❒	❒
4.	Takes medication daily? (if yes, what?) Required medication at school? ____	❒ ❒	❒ ❒
5.	Ever had heart disease, murmur, irregular heart beat?	❒	❒
6.	Ever had seizures?	❒	❒
7.	Wears glasses or contact lenses?	❒	❒
8.	Ever had kidney/liver disease or enlarged organ?	❒	❒
9.	Ever had asthma or lung disease (carries inhaler?)	❒	❒
10.	Any bleeding tendency, blood disease, anemia?	❒	❒
11.	Any allergies (bee sting, food, latex, medication?) __________________________________ Has allergy required any emergency treatment? __________________________________ Do you carry an Epi-Pen?____	❒ ❒ ❒	❒ ❒ ❒
12.	Ever had loss of eye, kidney, testicle, or other organ?	❒	❒
13.	Is diabetic or hypoglycemic?	❒	❒
14.	Ever had loss of consciousness, fainting, concussion, or frequent headaches?	❒	❒
15.	Ever have severe or recurrent chest pains?	❒	❒
16.	Ever have difficulty breathing?	❒	❒
17.	Wear braces, had teeth capped, or replaced artificially?	❒	❒
18.	Hearing impaired?	❒	❒
19.	Has impaired use of arms or legs?	❒	❒
20.	Has consulted with physician in past six months regarding any physical condition not listed above?	❒	❒
21.	Has any condition that may be worsened by playing sports or physical education?	❒	❒
22.	Any reason should not participate in all sports?	❒	❒
23.	Has any condition that would be considered life threatening?	❒	❒
24.	Has severe or chronic medical condition that requires special accommodations in a school setting?	❒	❒

Please explain **"Yes"** answers to above questions (give dates)

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Date of last physical: ____

PLEASE TURN OVER

Explain all **"Yes"** answers (give dates)

DISEASES	YES	NO		YES	NO
Chicken Pox	❐	❐	Rheumatic Fever	❐	❐
Ear Infections (frequent)	❐	❐	Rubella	❐	❐
Hepatitis A or B	❐	❐	Scarlet Fever	❐	❐
Measles	❐	❐	Strep Throat (frequent)	❐	❐
Mononucleosis	❐	❐	Tuberculosis	❐	❐
Mumps	❐	❐	Whooping Cough	❐	❐

CONDITIONS	YES	NO		YES	NO		YES	NO
Asthma	❐	❐	Ear Problems	❐	❐	Menstrual Problems	❐	❐
Arthritis	❐	❐	Eating Disorder	❐	❐	Muscular Dystrophy	❐	❐
Blood Disorder	❐	❐	Emotional Problems	❐	❐	Neurological Problems	❐	❐
Cystic Fibrosis	❐	❐	Eye Problems	❐	❐	Orthopedic Problems	❐	❐
Cerebral Palsy	❐	❐	Heart Defect	❐	❐	Rheumatic Fever	❐	❐
Chronic Illness	❐	❐	Hernia	❐	❐	Scoliosis	❐	❐
Dental Problems	❐	❐	Language Disorder	❐	❐	Sickle Cell Anemia	❐	❐
Diabetes	❐	❐	Loss of Paired Organ	❐	❐	Other (specify)	❐	❐

Difficulty with: ❐ Eating ❐ Hearing ❐ Speaking ❐ Swallowing ❐ Vision ❐ Walking

Please explain **"Yes"** answers to above questions (give dates)

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Medication Information

PLEASE NOTE: Any medication given at school (prescription or non-prescription) requires a doctor's order, parent's authorization and parent has to deliver medication to the school nurse in a labeled prescription bottle.

This information may be shared with appropriate faculty/staff members ☐ Yes ☐No

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Parent Signature

REVISED
3:12 pm, May 17, 2017